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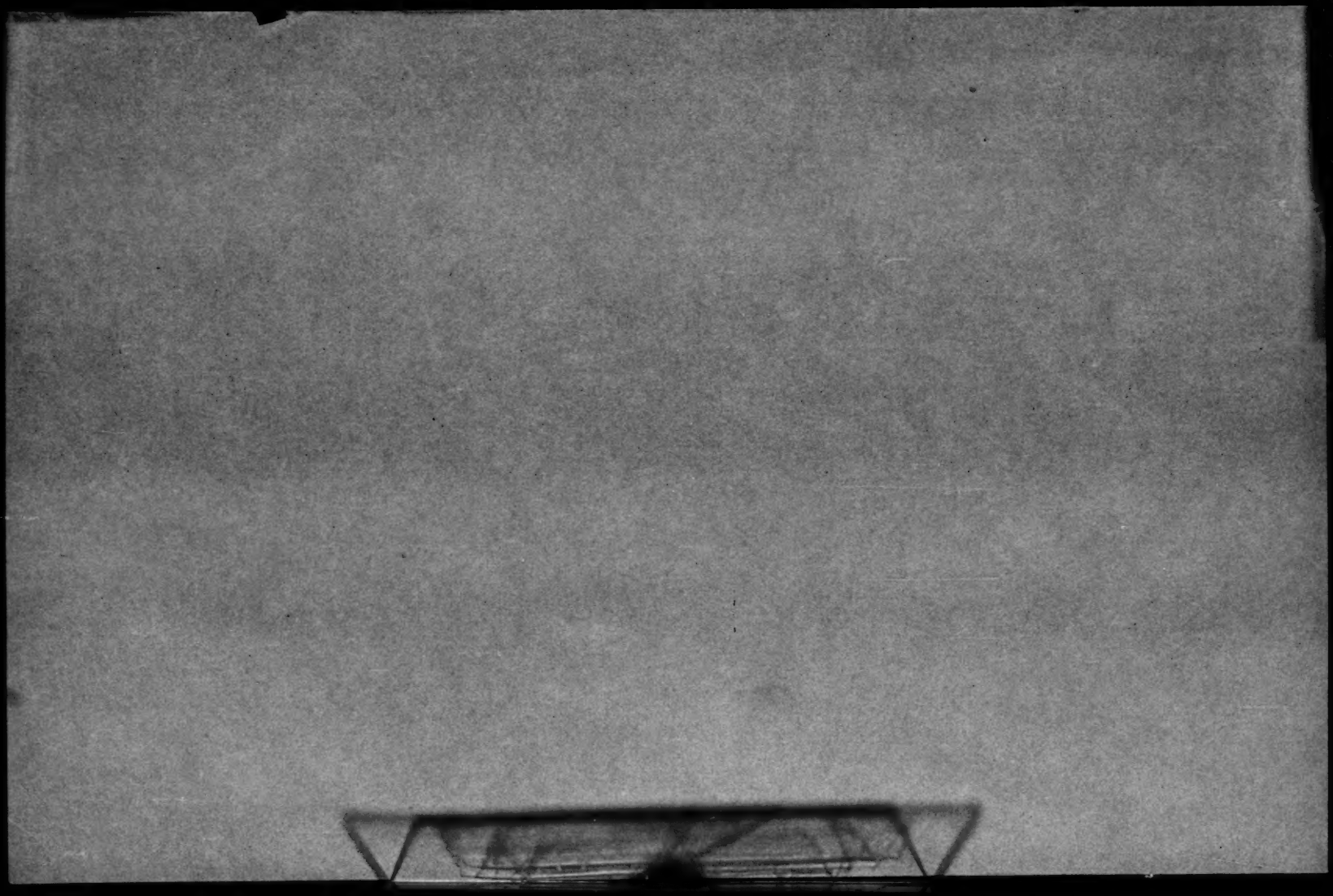

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A RESIDENTIAL TREATMENT UNIT WITHIN A STATE SCHOOL FOR DELINQUENTS: AN EXPERIMENT

BY RALPH W. COLTHARP, M. D.,* AND GEORGE H. WEBER, M. A.**

It is only natural to find a heterogeneous population in a state school for delinquents which operates without a selective intake of students.† In this population, are an appreciable number of severely emotionally disturbed children who are not able to profit from what is generally known as "group living and experiences" in relatively large groups. Since there are practically no facilities for emotionally disturbed children in the state of Kansas to help meet this problem, or treat these children, a small treatment unit was set up as a pilot unit at the Kansas Boys Industrial School (hereinafter referred to as KBIS) in October 1949.‡

The Setting and Personnel

Since no extra funds were available and the demand for treatment was great, the space on hand was used—in this case the infirmary. It occupies a wing of one of the buildings and consists of seven rooms.

The infirmary was staffed with one nurse and two hospital attendants who assumed regular duties with the treatment unit; and one additional hospital attendant was hired. A psychiatrist and a psychologist (already on the staff) assumed responsibility for the unit as additional duties. The psychiatrist assumed the over-all supervision. The psychologist assisted the psychiatrist in planning and did much of the group work in the early months. The other members of the staff carried on various activities as well as the everyday management of the unit. Although a few of the workers had some training and experience in working with maladjusted children, no one had any experience with this type of unit.

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†Of 100 consecutive admissions during 1950, the conditions of the boys were classified as follows: 15 per cent psychotic, 29 per cent emotional maladjustment of adolescence, 29 per cent neurotic character disorder, 15 per cent psychopathic character disorder, 6 per cent mental deficiency, 1 per cent juvenile paresis, and 5 per cent undiagnosed.

‡For information about the general Kansas Boys Industrial School program see, Colt-harp, Ralph W., and Weber, George H.: The Kansas Boys Industrial School treatment program. Bull. Menninger Clin., 14:102-107, May 1950.

Selection of Patients

Generally, admissions were accepted upon the recommendations of the clinical staff meetings. The boys were selected from the general population of the school on the basis of (1) the severity of illness, (2) inability to adjust in given cottage groups, and (3) the need for more individual attention. It should be mentioned here that the selection was not controlled in a manner which would have been desirable, because, with a personnel somewhat better equipped than other units, and possessing some technical know-how, the writers often were obligated to take severely disturbed boys, as well as boys with special problems whom they were not prepared to manage or treat.

Originally it had been intended to treat only pre-adolescents (age 10 to 12) in the unit; but during the 18 months covered by this report, the focus shifted to treatment of adolescents (boys aged 13 to 16). This was mainly determined by the intense need of this age group.

The total capacity of the unit was 11; and over a period of 14 months, 21 boys were admitted. Of these seven were psychotic (five were schizophrenic, one was a juvenile paretic, and the other was a psychotic depressive). Of the schizophrenic group, two were aggressive and hyperactive, and three were paranoid and withdrawn. Of the remainder, five were borderline psychotics, and the rest were cases of character disorders with strong neurotic trends. In addition, five other boys were admitted to the unit for acute psychotic episodes from which they recovered and were returned to their units at the school without continued special care.

The Treatment Methods

The treatment methods were of necessity varied and attempted to meet the needs particular to the boys living in the unit and the problems which arose out of this particular social situation, as well as out of the general school environment. They consisted of systematizing the activities, attitudes and group discussions of the living-unit and co-ordinating some of the outside activities in the work assignments, academic and vocational school, and some recreation in the community. In some cases individual psychotherapy was also utilized. These methods were viewed as being techniques which would (1) permit a release for pent-up feelings; (2) re-channelize impulses, into more socially acceptable behavior; (3) build

positive interpersonal relationships and encourage favorable identifications; and (4) provide experiences from which the boy could gain some insight into his behavior.

The Experiment

Although a wide variety of personalities were ultimately admitted to the unit, it was begun with the admission of five extremely active and aggressively destructive pre-adolescent boys. Prior to admission, several meetings were held with them and an effort was made to discuss in concrete terms their general adjustment problems and the probability that, with their responsible participation in a program of activities and discussions, their condition could be at least somewhat improved. Immediately, the change meant leaving their current living unit and moving into the hospital; leaving their cottage staff and relating to other staff members in the hospital; leaving their friends, except for associations in school and play activities around the grounds. Except for the initial reluctance of one boy, who had a close relationship to his cottage mother, the group enthusiastically, and generally irresponsibly, requested the move. The move was delayed for a short period of time with the hope that further discussions would clarify the program and gain more responsible acceptance on their part. This did not occur, and approximately two weeks after the initial discussion the move occurred. Although this orientation seemed to have very little immediate effect (because of the boys' inability to sustain attention and concentration), it was observed later that it did provide some basis for future understanding.

During the early months of their residence, these boys were severely disturbed and extremely destructive. Their destruction of the living unit was carried out in a variety of ways. Frequently they were sly and subtle, often the destructiveness occurred during rage outbursts, sometimes they were open and defiant in their manner. They broke windows, screens and light bulbs, knocked holes in the walls and knocked the transoms out above the doors, jammed locks, tore their mattresses, took their bed springs apart and used them to make steel darts and picks to open locks, removed some of the bed posts from their beds to use as steel clubs, plugged toilet seats and other drains, tore the insulation from steam pipes, disconnected radiators, removed knobs from doors and water faucets, broke tables and chairs, dismantled and de-

stroyed a radio, piano and a phonograph, demolished all their Christmas gifts within several days, built fires in their rooms with papers and sometimes with their clothes, and carried metal objects into the living unit where they were "planted" for use in fights. They shunned washing, change of clothes, haircuts and grooming, but sometimes enjoyed playing in sewer water.

The eating activities of these boys were also illuminating. They devoured and gulped their food rapidly, frequently eating with their hands. They threw food at each other and put their hands into each others' food. And while they ate ravenously—and although they attempted to destroy everything else with which they come in contact—they always treated the refrigerator and stove of the living unit with great care.

Their initial group play in the living unit consisted of running up and down the hallways and knocking each other down. Occasionally an individual would play with whatever was available. This play was primitive in that it amounted to pounding sticks or rolling rocks or pushing more formal toys around aggressively. This individual play was usually short-lived. If the individual did not stop spontaneously, other members of the group would interrupt the play. As these boys became less emotionally charged, and as they developed into a group, they did a great deal of spontaneous play-acting. This acting began without suggestion or encouragement and continued many times for several hours at a time. In the play area, they generally ignored the formal play equipment, frequently climbed tall trees, swung around in them with ropes attached to the limbs, and broke the dead limbs from the trees. Often they used the dead limbs for fights or fuel for unauthorized fires; sometimes they broke the limbs and spread them on the grass to jam lawn mowers. Rock fights occurred more than occasionally. Sometimes they climbed up the side of buildings, clinging to the down spouts as they ascended. When they reached the top they would run around on the roof and if asked to come down they frequently would curse, spit or urinate down at the staff member, as well as tear slate shingles from the roof and hurl them down at him. These boys also used their unusual quickness, nimbleness, alertness, and general agility to catch birds, pigeons and squirrels. They either would kill the animal immediately or profess a desire to retain it as a pet, only to kill it later when angry.

Efforts to hold group discussions with the boys were met by a whirl of shifting activity, e. g., constant rotation of the members participating in a card game; climbing up a steam pipe to the top of the room, spitting down on the group, and finally jumping down (often on other members of the group); running around the room; arguing, fighting, and shouting to other boys outside the building on the grounds. Sometimes a boy would crawl under the table to smoke. He soon would be joined by some of the other boys, and they would invariably begin fighting in several minutes over the division of the cigarette. Any efforts of the group leader even to introduce conversation were generally ignored. If a boy responded, the others would disrupt the communication by loud arguments and fights among themselves or against the interested boy. The discussion leader was frequently accused of "always wanting to talk," "always wanting to make trouble." Often a boy would playfully, yet aggressively, try to get the discussion leader involved in a scuffle.

Such activity would usually continue in these gatherings with increasing intensity until the boys were permitted to function in a broader environment. A broader environment did not change their behavior appreciably, it only provided more space and objects to absorb the energy.

More than occasionally the group would not follow its program, but became involved in destructive behavior about the grounds of the school. For example: One day the members got into the chapel of the school, which they turned upside down, urinating, defecating and spraying the contents of several fire extinguishers over the pews; at another time, they got into the tunnels that lead from building to building of the school and knocked out many of the light bulbs.

In the academic area, the group fared little better. The KBIS academic school which these boys attended emphasized individualized programs within a group framework, and the teachers offered a great deal of guidance and assistance. Yet these boys were frequently unable to make even a marginal adjustment in this adaptable program and returned to the living unit to function in a more limited environment.

In spite of their disturbed condition, supervised contacts with regular community life were provided. Difficulties presented them-

selves frequently; they cursed people, made sexual suggestions to girls and women, and stole.

Although nonpunitive restrictions were given, the boys' destructiveness, as well as some of their other behavior, was viewed as unacceptable in a matter-of-fact, firm, consistent, attitude. In other contacts, the staff approached them with an accepting, actively friendly attitude.

In an effort to assist the group constructively to control their destructive impulses, the supervision, guidance, activities and general planning were intensified. This increased planning, permitting very little free time, was too intensive and appeared to increase hyperactivity even though it did decrease destructiveness. With an allowance of approximately two hours of unscheduled time the boys seemed to slow down considerably. Initially they used this time mainly for sleeping, then fighting, and, finally more constructively, in individual building of model airplanes, kites, dog houses, etc. This slowdown could be attributed partly to the positive effects of the general environment.

Although the living unit provided regular arts, crafts, and recreational activities, many projects were planned from the cues given by the boys and the limitations of the setting. As a part of a project to make more play space available to them in the living unit, their services were enlisted to knock a hole in an eight-inch brick wall. Upon completion, this was used as an entrance to an adjoining room. The boys liked this type of activity so well that arrangements were made with the maintenance department to employ them when it needed to have something destroyed or wrecked. Old clocks and motors were given to them to "work on." This gave them something with which to tinker and eventually destroy. Their breaking of dead limbs from trees was organized so that dead limbs were systematically pulled off, and broken for fire wood, which was saved and taken on camping trips. Hikes through wooded areas where the undergrowth was thick gave the boys an opportunity to use clubs to beat their way through the brush, and establish what they called the jungle trail.

Activities to satisfy their needs to destroy things, get dirty and find things of value were also arranged. Two boys requested and received a part-time work assignment of keeping the area close to the school incinerator clean. On this job, they enjoyed the scavenger activity of going through all the discarded junk, getting ex-

tremely dirty and salvaging articles which appealed to them. Smashing the refuse and assisting a staff member to burn some of the material also was thoroughly enjoyed.

In play activity, these needs were also met by difficult treasure hunts in which the boys had to dig, roll logs, climb trees, etc.

The initial treatment of animals improved—perhaps in part because of a project. One of the boys found a litter of puppies under a bush and a project of caring for them was planned. This included carrying food to them and building a house for them which first involved the tearing apart of packing crates and salvaging the lumber. The group became rather attached to these dogs.

In addition to these activities, finger painting, water coloring, soap carving, clay working, leather working, braiding and general arts and crafts were carried on regularly with the group. Although these activities proved helpful, it should be mentioned that many times the finger paint, and clay and water for water coloring were thrown at each other rather than used for more acceptable expressions. And the leather and braiding were used for whips.

In some of these situations, particularly when fighting each other, some of the boys' hostility and fear became sufficiently crystallized to give them enough concern to want help in the immediate situation. Although short, the resulting highly-charged discussions seemed helpful and prepared the way for more organized discussions in future.

The spontaneous play acting was encouraged, and efforts were made to have the boys increase the expression of their thoughts and feelings along with the acting. They enthusiastically recorded their play on a wire recorder, and they generally wanted to listen to the playback, even though it frequently made them anxious. This technique was used mainly for expression although some interpretive use was also made. The major themes of their play centered around disturbed family relationships and anti-social activity. Sex was one of their major themes, besides being included in many other themes. Physical aggression was always an important means of expression. When their play involved disturbed family relationships, it would frequently include a great deal of verbal and physical strife, particularly among the parent figures, as well as the other members of the family. Sexual approaches of the father to the mother would invariably follow parental quarreling and fighting. The anti-social play usually consisted of a suave,

breezy, "tough" character burglarizing a place of business and "fighting it out" with the "cops." Initially all the boys wanted to play the prized role of the "crooks," and the action of the police was weak. However, as adjustment progressed, the role of the "crook" was less attractive, the "cops" becoming a stronger and a more effective force.

As they became better adjusted and were able to meet reality demands, the boys' acceptable behavior increased, firmer attitudes were used in reaction to their destructiveness and restrictions were invoked when they appeared appropriate and constructive.

After the unit had been functioning for several months, various staff members requested that additional boys be admitted. Some made their recommendations with a sincere hope that they would be helpful to the boys; others were only trying to pass very difficult problems along for their own convenience; and still others appeared to want to overload the unit to bring about its certain failure. Although not always possible, efforts were made to admit boys who could offset the extreme destructive nature of the original group. So some less impulsive and more reflective, as well as some withdrawn, adolescent boys were admitted. The admissions which followed were gradual. The new boys adapted themselves rather well to each other but generally held themselves aloof and took a superior attitude toward the younger, more openly aggressive, boys. Their aloof attitude later turned to one of condescension. The more reflective older boys exploited the more impulsive younger ones by having them carry out many of their own latent aggressive impulses.

In turn, the impulsive and openly aggressive boys affected the less aggressive boys in that they excited them into acting out some of their latent aggressive impulses, often stirring the withdrawn boys into rage outbursts. As these different boys became less mutually agitating and gained some group unity, the reflective boys assumed the intellectual leadership for the group, and the other boys gave force to or actually carried out their ideas.

During the early phases of the group's integration much of its activity was anti-social, and this found many devious expressions. The more intelligent and thoughtful leadership influenced the expressions from those of violence and destruction to those of conniving, shrewdness and scheming.

This more complex group made program work more difficult as it increased rivalry among the boys for adult attention, and seemingly increased the number and intensity of unhealthy love attachments among the boys. There were some positive aspects which came out of their associations. The more reflective boys, because of their generally calm and unruffled nature, many times slowed the tempo of the group and imparted a more thorough and thoughtful approach. Their broader range of constructive interests stimulated the total group; many times they assumed constructive and protective attitudes toward the other boys and sometimes even gave excellent counsel.

With the addition of the new boys to the unit, group discussion took on new meanings. With the aggressive boys, group discussions of the more usual type were not possible; however, with the addition of the more reflective boys they became one of the most effective approaches.

After the initial group meeting with the extremely disturbed boys, the group discussions were held three times weekly at the end of the day, with the psychiatrist or psychologist as the group leader. Free expressions of ideas were allowed, but the group leader discouraged fighting, encouraging instead group integration and reflection on the events of the day. Planning for the group was also encouraged, and an attempt was made to develop a "group conscience." Initially all that was possible was to tell the boys that the staff members would meet with them regularly to discuss the day-to-day problems, and would plan for their recreation. Also the boys were encouraged to participate in the discussion of discipline problems.

The group, after about two months of disorganized activity, began to depend upon the meetings and would feel hurt if the meetings were not held at the exactly appointed times. Simultaneously, they would ask for group meetings when emergencies arose, hoping to get some sort of group action. Shortly after this, some of the boys began to show evidence of assuming leadership and identifying with the group leader. In addition, some began to insist upon some order in the group where previously much had been bedlam.

In summary, the results of the meetings may be said to have been favorable in that they created group cohesiveness, group conscience, group morale, identification with the leader and served

as media by which some difficult problems could be settled. Heated comments directed toward each other were utilized to encourage discussion along constructive lines. For instance one boy accused another of being a thief and asked that he be put out of the group. Another replied to this, "You guys ain't so damned good or you wouldn't be here." Such acute remarks were vehicles for discussions and helped create awareness of their social and personal problems. Remarks accusing one another unfairly were sometimes interrupted by the group leader; or if it appeared there was danger of a complete break-down of group discussion, the leader often assumed a very firm position. This seemed to relieve much anxiety.

Results—Evaluation

In evaluating experiences in establishing a unit for severely disturbed boys in a state institution for delinquents, the writers will consider the project in view of what happened to the boys in the unit, the boys outside the unit, the staff and the community.

Two of the unit's boys were returned to their regular units. One was much improved, the other unimproved. The latter needed a firmer environment, with boys his own age, and seemed to respond to a more suppressive management. Another boy was committed to the state reformatory after having escaped many times, and having committed many anti-social acts while away. Three boys were committed to the state hospital because they were of an older age group, and the writers had difficulty in managing them in their own unit. Seven were released from the school to return home, having improved sufficiently to make satisfactory adjustments in the community. Of the remainder, all are making considerably improved adjustments as judged by their overt behavior and by their mental status. The gradual degree of relaxation after being in this unit, as well as their ease with adults, was striking. The shy, withdrawn boys brightened perceptibly. The faces of the schizophrenic boys showed gratifying changes from a pasty, flat expression to one of life and near-appropriate responses. Although the boys with character disorders were more difficult, some for whom, the writers had thought, there was little hope, showed good capacity for identification, creative activity and generally constructive development.

It would appear that these boys improved because of more individual attention, less suppression, group therapy, some individual therapy, educational and recreational facilities—in other words, a total approach—representing the combined effort of a number of people, avoiding the typical industrial school techniques.

Initially the other boys in the institution reacted with mixed feelings, some showing recognition of the boys' problems by calling them "nuts," "screw balls," "crazy," and the like, while others initially wanted to be admitted also. Since the unit started, over one-half of the boys in the school have requested admission, presumably because of the smaller unit, relatively relaxed atmosphere, permissiveness, and enriched daily activity.

Although there was some preliminary orientation, the staff of the school as a whole reacted with mixtures of approval, anxiety and hostility. Since this represented a frank break in the traditional management of boys within the school, house parents were threatened by what seemed to be undue permissiveness or by what, at other times, seemed to be outright approval of destructiveness. Also, since management was on the basis of psychological and social needs, it appeared to be incomprehensible to some; and others feared that this management would be foisted on them. They also feared, with justification, that juvenile aggressive activity would be contagious to their own groups. The considerable destruction of property and the concentrated number of severely disturbed boys aroused many latent problems among the personnel. Although the unit was sometimes the subject of ridicule by cottage parents, they were always happy to transfer their more disturbed boys to it, rather than keep them as disturbing influences to themselves and their own units.

The writers' own initial mistake was one of not being firm enough. This fact heightened the anxiety of the staff, as well as of the children. Often when the psychologist or psychiatrist had to serve as the one to provide physical management, the writers found themselves as a result much more kindly disposed toward the cottage parents, of whom they had previously been critical. The writers heartily recommend that all professional personnel who would advise others in the management of disturbed children have some first-hand experience of this nature.

As a result of the establishment of this unit the community began to expect more services for psychotic children from the school,

since many were helped and virtually no such facilities exist in the area.

Discussion

The establishment of a special unit for severely emotionally-disturbed boys in an industrial school presents many problems. Not only should emotionally-disturbed children be separated from the general population of delinquents, but they also should be further separated among themselves. A high ratio of well-trained personnel is essential. Adequate orientation and reasonable acceptance of the entire staff facilitate operation; and, in a new setting, one should not be surprised at strong staff resistance. A near-indestructible physical plant is needed. There is likely to be a tendency toward being too permissive, and this is damaging, in that it increases the anxiety of the staff, as well as of the children. Establishment of this sort of unit, in which some professional personnel are utilized in the actual physical management of disturbed children, proves to be a valuable workshop for those who would guide others in such management. The use of group therapy, individual therapy and much on-the-spot counseling was most helpful. The unit created an awareness of the needs for such units by the boys, the staff and the community. Perhaps the most favorable aspect of such a unit is that it generally demonstrates techniques for management to the remainder of the institution, and helps increase the awareness of the public to the fact that juvenile delinquents do have emotional problems.

Boys Industrial School
Topeka, Kas.

DIAGNOSING "SUICIDAL RISKS" ON THE RORSCHACH

BY MARY ALICE WHITE, Ph.D., AND HANNA SCHREIBER, M. A.

The writers of this paper believe it is of critical importance for the clinical psychologist, as part of his responsibility as a member of the clinical team, to be able to state whether, in his opinion, a patient is or is not a suicidal risk at the time of testing.

Criteria

Any technique that presumes to give this sort of information should meet certain criteria. It should:

1. Tell the competent interpreter whether the patient is a *suicidal risk at the time of examination,* and in the near future, not whether the patient was suicidal sometime in the past. The clinical team is concerned with management of suicidal risks in the present and future.
2. Be verified as a technique in a clinical setting where a great variety of patients are seen, and examined without knowledge of the history or of the diagnosis.
3. Define "suicidal risk" in terms of clinical evidence that is both explicit and reasonable, so that the limitations and usefulness of the technique are thoroughly understood.

In the writers' experience, the Rorschach has proved the most valuable psychological tool for this task. However, the available literature on "suicidal Rorschachs" fails to meet the criteria stated. Signs or configurations are often reported as indicators of suicidal tendencies. Often, such signs are just translations of a psychiatric diagnosis, such as reactive depression, anxiety state, or manic-depressive psychosis, mixed type; and the writers have not found that such illnesses are synonymous with being suicidal, or that a patient suffering from such an illness is suicidal at all stages in the illness. Signs are often piecemeal affairs, and it is the writers' belief that the Rorschach provides no such ready-made device to tell one whether a patient will attempt to take his life. The writers have found that the evaluation of suicidal risks requires a careful weighing and thinking out of the whole patient, both by Rorschach content and by scoring, before such a serious decision can be reached. This process takes time and it takes judgment, which makes it all the more difficult to describe and communicate in an article of this type, where clinicians search for a

technique that is easy to apply in some mathematical or statistical way.

Also in the Rorschach literature, is the problem of defining "suicidal risks." Evidence may be offered that the patient was deemed suicidal on the basis of the medical staff's judgment, or because the case history "revealed the presence of suicidal talk, suicidal ideas, suicidal attempts, or actual suicides. . . ."* But *when?* What was the time interval between the Rorschach administration and the suicidal behavior? An experienced Rorschach clinician can diagnose a manic-depressive, mixed, or an involutional melancholiac. This same clinician can then infer that this patient shows suicidal tendencies—either by using signs as a substitute for the diagnosis—or simply through using his clinical knowledge about this type of illness. A check of the case history is very likely to reveal suicidal ideas, talk, or attempts *at some time* in the patient's life. This can be interpreted to mean substantiation of the signs or pattern used.

Actually the Rorschach clinician who works in a clinical setting is faced with this paramount problem: "Is this patient to whom I have just administered the Rorschach a suicidal risk now and/or in the foreseeable future?" In such cases, one is faced with the realistic problem of the patient's welfare and management today, tomorrow, and in the near future, not with the risk he might have been two years ago.

The writers therefore, have set up two types of standards for defining suicidal risk against which to judge their results: (1) evidence of certain suicidal behavior which (2) shows itself within a reasonably short period from the Rorschach administration. These standards are detailed as follows:

The Rorschach interpretation of a suicidal risk *is considered substantiated*:

1. When a patient (a) *makes a suicidal attempt*; (b) *expresses suicidal thoughts or threats*; (c) *commits suicide;* (d) *does none of these things but is on "C. O."* (constant nursing observation instituted when a patient is considered a serious suicidal risk at any period during hospitalization).

2. (a) *Provided any of the foregoing* (except "c" of course) *occurred immediately prior to testing.* By "immediately prior," it is meant, for example, that such suicidal behavior would have had

*Ref. 5, p. 49.

to have been one cause for admission to the hospital (to verify an admission Rorschach deemed suicidal). An attempt made a year before admission or in a previous illness is not evidence that the patient was clinically suicidal at the time of the admission Rorschach. (b) *Provided any of the foregoing occur immediately after the Rorschach administration.* By "immediately after," is meant a period of approximately two months. Of course there are exceptions; and two months is not a time interval that can be used without careful weighing of the circumstances. The writers have taken enough Rorschachs at two-month intervals to know that the picture can change radically within such a period. A major change in the patient's environment immediately following the Rorschach, such as divorce, death of a friend or relative, or severe financial loss, obviously could affect the patient, and one would not necessarily expect the previously-administered Rorschach to remain descriptive in the changed situation. In manic-depressive psychosis, circular type, a mood swing can occur suddenly and it is not known how to predict it accurately enough on the Rorschach. If the patient's environment has been relatively unchanged, and if the patient's condition has not changed drastically, as in a circular illness, it can be expected that the Rorschach interpretation will hold good for about a two-month period following the date of administration.

The writers have added a fifth category of clinical evidence, "depressed," in cases in which a patient was severely depressed within the time intervals outlined, but in which none of the four standards of suicidal behavior was met. This was added as a sort of no-man's-ground where suicidal tendencies were a constant possibility but never frankly evidenced. The writers do not know if the Rorschach interpretation of suicidal risk was wrong or right in such patients, but do not include it as right.

The sixth and last category for checking results was "none of the foregoing." The findings were considered to be inconsistent and unverified in this group.

Population

The population to whom these standards have been applied, and to whom the writers have administered the Rorschach over the past few years consists of patients in a private psychiatric hospital. The implications of the findings are limited to patients of

the type to be described. They range in age from 18 to about 75, and represent a superior sample in education and socio-economic status to that of the average population. Intelligence varies around 120, full I. Q., on the Wechsler-Bellevue, with an I. Q. of below 110 rather unusual. All patients are seen on admission, without knowledge of history or diagnosis, and again on discharge, unless EST has been given within six weeks of the proposed testing or unless an occasional patient is too ill physically. A large percentage of the patients are seen once, twice, or three times more during their hospitalization for a variety of reasons, one of which can be the evaluation of suicidal tendencies.

In this way about 1,250 Rorschachs, which were consistently administered, scored, and interpreted, have been collected since 1947. Of these 1,250, 105 patients' protocols were judged "suicidal risks" by the method which will be presented later.

Results

The writers expected the frequency of agreement between Rorschach and clinical evidence to be considerably lower than reported elsewhere, simply because the writers' standards of actual suicidal behavior within a short time would force the dropping of a large number of cases.

The clinical accuracy of the Rorschach prediction in these 105 cases is shown in Table 1. These figures are interpreted to mean that 77.2 per cent of the 105 patients who were called "suicidal risks" on the Rorschach showed adequate evidence of this clinically. In applying the technique, the writers now expect that three out of four patients who are called "suicidal risks" on the Ror-

Table 1. Clinical Data for Rorschach "Suicidal Risk" Group

	Women	Men	Total	Percentage
1. Attempted suicide	33	7	40	38.2
2. Suicidal subsequently	3	1	4	3.8
3. Suicidal thoughts, threats	18	11	29	27.6
4. On C. O.	4	4	8	7.6
Subtotal	58	23	81	77.2
5. Depressed, but none of foregoing indications	10	2	12	11.4
6. None of foregoing	9	3	12	11.4
Total	77	28	105	100.0

schach will consider, threaten, or attempt suicide within the time and conditions defined earlier.

It should be understood that nearly all patients are diagnosed on the Rorschach according to the accepted classification of mental illness, and that the diagnosis of "suicidal risk" is made quite apart from naming the particular mental illness the writers believe a patient to have. One might suppose that knowledge of one would lead to the other. Table 2 presents the clinical diagnoses of these 105 patients. The writers think it is very interesting that practically every functional diagnosis is represented, contrary to the frequent view that suicidal Rorschachs occur mostly in neurotics. (This table, of course, is only for a hospitalized group.) A comparison of the distribution of the diagnoses in Table 2 with the distribution of diagnoses for all patients admitted to this hospital in 1949 shows a close similarity in percentages for each group. It is the writers' first conclusion therefore, that Rorschach "suicidal risks" occur in all the functional illnesses in proportion to the frequencies of those illnesses in the population studied.

Table 2. Clinical Diagnosis of "Suicidal Risk" Group

		Women	Men	Total	Percentage
A.					
1.	Dementia præcox, catatonic	14	2	16	
2.	Dementia præcox, other types, depressed	2	0	2	
3.	Dementia præcox, paranoid	2	3	5	
		18	5	23	22.0
B.					
4.	Manic-depression, depressed	7	3	10	
5.	Manic-depression, mixed	5	3	8	
6.	Manic-depression, manic	2	2	4	
7.	Manic-depression, circular	10	1	11	
8.	Manic-depression, perplexed	0	1	1	
		24	10	34	32.3
C.					
9.	Involutional melancholia	1	1	2	
10.	Involution psychosis, paranoid	3	0	3	
		4	1	5	4.7
D.					
11.	Psychoneurosis, mixed	11	5	16	
12.	Psychoneurosis, reactive depression	5	2	7	
		16	7	23	22.0

E. Other illnesses				
13. Psychopathic personality	0	1	1	
14. Psychosis with psychopathic personality, episode of depression	3	1	4	
15. Psychopathic personality, pathological emotionality	2	0	2	
16. Psychosis with psychopathic personality, episode of excitement	1	0	1	
17. Without mental disorder, alcoholism	4	1	5	
18. Paranoid condition	2	2	4	
19. Psychosis with mental deficiency	1	0	1	
20. Psychosis with other infectious diseases (atypical pneumonia)	1	0	1	
21. Without mental disorder, drug addiction (barbiturates)	1	0	1	
	15	5	20	19.0
Total	77	28	105	100.0

There is no one illness that is "suicidal." We feel strongly suicidal trends depend on the *type of patient* in the illness, and on *what point* has been reached in the illness. This finding of course does not hold for those who actually succeed in committing suicide. The data on actual suicides for the national population differs substantially from what the writers consider "risks." Many unknown factors affect the actual rate of fatality, many of the fatalities occurring outside of any type of treatment.

The age and sex of the 105 patients also showed a distribution consistent with the hospital population, so a Rorschach "suicidal risk" seems to be independent of these two factors also. An analysis of the 12 patients in the sixth ("none of the foregoing") category, whom the writers apparently misdiagnosed, showed no weighting by diagnosis, age, or sex.

Test Run

In addition to demonstrating how clinical data does or does not substantiate the Rorschach diagnosis of "suicidal risk," it seems fair to ask the question, "But how many clinically suicidal patients are missed with this technique?" The literature often establishes the first validation, but writers fail to answer this second question and fail to work from the clinical material first rather than from the Rorschach.*

*Ref. 5, p. 60.

To answer this question, 60 consecutive admissions to this same hospital beginning October 1, 1950 were selected as a "test run." These 60 patients represented 18 per cent of the total of 329 admitted during the year (males 19 per cent, females 18 per cent). This was a representative sample, consisting of almost two months consecutive admissions. The case histories were studied so that the 60 patients could be divided into three groups, as of the time of their admission which was the time of their first Rorschachs: (A) not suicidal clinically, (B) depressed clinically (C) suicidal clinically. The same criteria and qualifications were used as in the first part of this study. All the Rorschachs were done "blind," and by that is meant that the examiners knew only the patient's name, age, date of admission, if admitted as an inebriate or drug addict, and occupational and educational attainments.

The results of this test run are shown in Table 3. They require a little explanation. In no case was a patient diagnosed suicidal

Table 3. Test Run Results

	Men	Women	Total
A. *Not suicidal clinically*	15	21	36
B. *Depressed clinically,* reported depressed on Rorschach	2	1	3
C. *Suicidal clinically*			
1. Reported suicidal on Rorschach	4	6	10
2. Organic masking effects on Rorschach, but reported deeply depressed	2	1	3
3. No Rorschach	0	4	4
4. Rorschach not suicidal, questionably wrong interpretation	0	2	2
5. Rorschach not suicidal, definitely wrong interpretation	1	1	2
	24	36	60

on the Rorschach who was not suicidal clinically. Of the 21 patients who were clinically suicidal at the time of admission, 10 were shown as "suicidal risks" on the Rorschach. Of the remaining 11, three were called depressed and also showed organicity; the writers feel that organicity has a masking effect on the Rorschach, so that it is not felt that there are clear pictures of the functional illnesses in cases that are reported in this manner. No Rorschach was obtained in four cases: One patient was too ill physically; one was a readmitted patient who had been worked up previously; a third had had EST before admission, rendering any

Rorschach invalid; and a fourth patient refused two attempts for paranoid reasons.

The Rorschach was not reported as suicidal in two cases where the patients were suicidal clinically, and these reports were judged questionable errors. The cases follow:

Patient 1. This patient was a female who had made a suicidal attempt leading to admission in what appeared to have been a dramatic gesture by a psychopathic personality. Some addiction was reported in the history. The Rorschach diagnosis was psychopathic personality with the patient capable of addiction.

Patient 2. This woman was admitted as a case of mixed psychoneurosis following childbirth. Suicidal ideas had been expressed before hospitalization. Her course in the hospital, compared to her two Rorschachs, was as follows: Admitted September 15, she made a reasonably good adjustment and was transferred to a semi-convalescent hall on October 2. (The first Rorschach was done September 20, with the patient reported "full of postpartum concepts, anxious, depressed, and hovering between psychoneurosis and catatonic schizophrenia.") On October 9, the patient had not reacted well to the change to a better hall, became depressed, and was moved back to the admission hall and placed on C. O. By October 23, she was off C. O., and considerably improved. During November and December, she showed continued gains and was again moved to a semi-convalescent hall in late December. (The second Rorschach, done November 30, showed improvement with her adjustment more psychoneurotic.) On December 21 she developed an acute intestinal obstruction, and was removed to a general hospital for surgery. When she did not return for further psychiatric care—which was deemed necessary—she was discharged as of January 3. The patient committed suicide by asphyxiation at home on January 5. It is an open question whether the patient should have been recognized as a suicidal risk when she was seen. The writers think she probably should have been judged a risk, but it is hard to evaluate the effects of the subsequent environmental changes.

The two patients of whom the Rorschach interpretation was definitely wrong were as follows:

Patient 3. This male, diagnosed catatonic schizophrenia, made a suicidal attempt prior to admission and was on C. O. at the time

of the Rorschach. The Rorschach reported schizophrenia, other types, depressed.

Patient 4. This female was diagnosed schizophrenia, other types, depressed. She had suicidal thoughts before admission, and was on C. O. at the time of the Rorschach. The Rorschach reported her capable of mood swings; she was diagnosed schizo-affective.

From Table 3 it is hard to compute a fair "batting average." It could be said that of the 21 patients who were clinically suicidal, a valid Rorschach was obtained in 14 cases. In these 14 cases, the Rorschach "suicidal risk" diagnosis was correct for 10 patients, or 71 per cent of the time. This of course is an extremely small group but a complete sample of actual experience during two consecutive months.

In summary, this technique correctly diagnosed "suicidal risks" 77 per cent of the time when clinical material was used later for validation. A small test run suggests that this technique misses about 30 per cent of the suicidal patients when one works from the clinical material back to the Rorschach. Using this technique within its defined limitations and criteria for accuracy, the writers would therefore expect to detect about three out of four suicidal patients in their daily work.

Description of the Technique

In describing interpretive technique on the Rorschach, one is tempted either to report statistical methods which others can use easily without results, or else to report hunches or clinical insights which others can't duplicate. In the technique which there will be an attempt to communicate in this paper, the writers assume that the experienced clinician would agree that no formulae or set of signs can be applied successfully to so complex a problem as deciding whether a patient will find all of life so unworthwhile that he will want to kill himself. The decision made by the patient is one reached after many experiences and for many reasons. The Rorschach clinician should expect to go through a careful examination of the patient's mood, attitudes toward life and toward death, and of the patient's personality resources and pathology. The writers believe there is no short cut.

1. *Mood*

The first step is to establish the patient's mood and attitudes toward his environment through a careful reading of the protocol itself. At this point, scoring should be totally ignored. The protocol should be read and reread in order to see through the patient's own eyes what life looks like to him. The type of concept that is important is outlined in Table 4 (Appendix). Themes of mutilation, death, anatomy, fright, suspension, darkness, aggression, passivity, and restlessness are the ones the writers have found to be critically important. In such records, what is left out is also important. Records that are significant here lack concepts of active people, normal people, or conventional scenes. The approach is never relaxed and easy. Either what is seen is reported with adjectives that describe the morbid feelings just noted; or, occasionally the record will be abnormally devoid of feeling. It is helpful to think of feelings as a continuum in suicidal patients, where the absence of feeling is as abnormal as fear, fright, or morbidity. Here the reference is not to the so-called flat affect of schizophrenia, when the term, devoid of feeling is used; because most schizophrenics are not "flat" on the Rorschach. Feelings are there, but they are attached to fantasies and unusual ideas rather than to the people or to the actual environment around them.

In using Table 4 (Appendix), the question will arise as to how many concepts are necessary to establish the basis for a suicidal risk. This table is not complete but is only suggestive of the kinds of concepts to look for. The question of quantity has to be answered in terms of each record. It depends on the total number of concepts and the amount of non-suicidal concepts. As in any Rorschach interpretation, the only answer is that this is a question of judgment: When one carefully reads through a protocol two or three times, and the protocol produces in the reader a rather morbid or frightened mood, the record is potentially suicidal. Usually there is more than one of the significant themes apparent. One would hardly conclude someone had a suicidal mood simply because anatomical responses were given. It is the combination of fright, despair, suspension, etc., that gives one the impression that this patient is anti-life. If one assumes that what the patient sees on the Rorschach reflects his attitude toward life as a whole, then the clinician should ask himself after reading the protocol,

"If this were my picture of life, would I feel like leaving it? Or is there enough here that's pleasant to make it worth while?"

2. *Behavior*

Once the anti-life mood is established, one cannot conclude the patient is a suicidal risk. There are many patients who feel life is a threat to them who will not commit suicide. They may endure a long depression instead; they may refuse to eat; they may drink habitually or take drugs; they may detach themselves from life to enter a world of delusion where they can either insulate themselves against life by withdrawal, or build up a fortress of paranoid systems, within which they can hide to snipe at life as it passes by. Some patients will go on indefinitely in this same state of fear and futility, never liking it but never leaving it, and others will get back their faith in the worthwhileness of living—which is the process of getting well.

Resolving the question of what course the patient will choose depends largely on the recapitulation of the Rorschach scoring—the "Rorschach recap." One may decide from the recapitulation that a patient has certain courses open to him, and one can never be sure which he'll take. In saying a patient is a "suicidal risk," all that is meant is that the suicidal course is one of the real possibilities. What happens to the patient and in the patient will bring the final decision.

Deciding what course or courses a patient, who has this suicidal mood, will take requires weighing one factor of the recapitulation against another, singly and in combination, to reach a judgment. Again, there are no neat signs and no short cuts. To describe what steps are gone through, the writers will have to explain their own approach to interpreting any "recap." The "recap" form they use is shown in Table 5; and following its form is essential to the method.

The writers like to think of personality structure, as they see it on the Rorschach, as consisting of four factors. They diagram it mentally as in the figure (p. 173). The circle represents the individual's contact with reality, his ability to perceive, and perform within the actual terms of his environment. If the circle is impaired, he may act with poor judgment, or misunderstand what happens about him, or follow his own bent to the detriment of others, or not respond to his environment at all. This circle, or

Table 5.

RORSCHACH RECAP

Name .....Age ..... Examiner..... Date.....

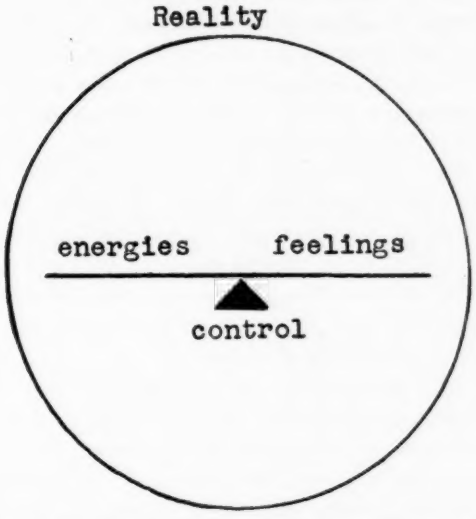
Artifacts .....

R—		P—		O—	
LOCATION		DETERMINANTS		CONTENT	
W	—	M	—	H	—
D	—	FM	—	Hd	—
d	—	Fm	—	A	—
Dd	—	mF	—	Ad	—
S	—	F	—	Anat	—
DW	—	Fdesc	—	Aobj	—
	———	FC′	—	Obj	—
Total =		C′F	—	Na	—
		FC	—	Sex	—
RATIOS		CF	—	Abstract	—
F%	=	F/C	—	Blood	—
SumC	=	C/F	—	X-ray	—
W:M	=	C	—	Map	—
(FM+m):(Fc+c+C′)=		Cn	—		———
A%		Cdesc	—	Total=	
M:sumC	=	Csym	—		
		Fc	—	SIGNIFICATION SIGNS	
NOTES		cF	—	DW	—
		Fk	—	Contam	—
		kF	—	Po	—
		KF	—	Do	—
		FK	—	Persev	—
			———	Rejections	—
		Total=		Long RT	—
				F Minus	—
				Odd	—
				Confused	—
				Vague	—
				Pers. Ref.	—
					———

contact with his environment, is derived from the Rorschach recap by evaluating the number of responses (R), number of populars (P), number of originals (O), location scores (W through DW), and Significant Signs. The less popular the concepts and the more abnormally they are perceived, the poorer the contact.

The line across the circle may be considered to be something like a seesaw, balanced on a fulcrum. The seesaw consists of energies on one side and feelings on the other. A person should have sufficient energies to be motivated, to perform intellectually and

Figure 1



physically in his environment. These energies on the recap are M, FM, Fm and mF. Feelings are the other side of the personality, and include the range from love to hate, gaiety to sadness, apathy to anxiety, warmth to coldness, sentiment to cynicism, etc. On the recap, these feelings are represented by the Rorschach scoring symbols beginning with FC′ down through FK. A person should have feelings through which to express his energies so that he may be a feeling person in society, as well as a thinking and acting person. There can be a pathological imbalance between the amount and type of energies and amount and type of feelings.

The fulcrum under the personality structure is F%. The reader will note that on the recap the two F symbols are placed between the energy score (M—mF) and the feeling scores (FC′—FK) so that the recap gives the same diagram of personality functioning as the figure. This F% is, to the writers, like a governor of the personality. It is the control mechanism that tells how well the personality can govern the delicate relation between energies and feelings. F is also a governor in controlling what the personality thinks, does, or feels within the circle of his environment. It is rather like a mediator between what the individual wants as an individual and what reality will permit, as represented by the circle.

Diagramatically speaking, a person is mentally ill in whom the

circle is broken, or whose seesaw is either tipped or unweighted, or whose fulcrum is out of place. Clinically speaking, mental disorder occurs when there is an abnormal increase or decrease in reality contact, energy, feeling or control. In every patient whom the writers have seen in this hospital population, there is more than one of these four factors which is impaired in illness; and the writers find they can diagnose a given mental illness by seeing which combination of these four factors is out of order. Because recap interpretation is understanding the relationship among these four factors, evaluating a patient requires that one approach the recap as a living picture of a personality, and think of these four aspects of its structure as having a relationship to each other that is very alive and constantly changing.

So much for the theoretical approach to the recap. The writers find it helpful and use it in this discussion, but it does not have to be taken literally or as more than an analogy. In evaluating the patient with a suicidal mood, what many of his feelings are, have already been established by reading his concepts. What isn't known is how he is going to behave. Each of the four areas is evaluated in turn, constantly raising questions that can be answered only by putting them all together in the final step.

A. REALITY CONTACT

First, the reality contact is analyzed. It may be "too good" or too bad. What is meant by "too good" should be explained. One rarely considers that anyone has too good a contact with reality; but, in a sense, that is what patients with psychotic depressions (particularly of the manic-depressive, depressed type) will show. Too good means that their form level is exceedingly accurate, and that although they see few things and most of them commonplace things, they see them with an abnormally high regard for their resemblance to reality. They lack imagination, and they can't approach the task casually. To them, the Rorschach is a problem in pure identification. They are so rigid they can only see what is literal—and right in front of their noses. Their approach is so excessively real that they can't see the range of their environment, or the forest for the trees. In terms of suicide, "too good" a reality contact can be an indication that a patient will feel "stuck" with his problems, which to him look insuperable. To him, they will loom overhead in a magnified way, and he will not see

that there is any way around them. Too good a contact with reality means: records of few responses; average to high P's in relation to the number of responses; no Significant Signs (except rejections); no O's; only D and W location signs, with more D's than W's, restricted content; and very high form level.

Poor reality contact is more obvious, meaning one either does not see the world as others do, and/or sees things in a way others can't share. Low P's, an occasional O, poor and varying form level with the presence of other Significant Signs, are the indications of poor reality contact that the Rorschach clinician would recognize.

Too good or too bad reality contact must be compared to the other three factors before one can evaluate its meaning in relation to suicide. At this stage in evaluation, all the writers would say is this: If reality contact is "too good," the patient may see no way around his problems, so one will have to be on the watch for the energy to make a suicidal attempt, for enough restlessness to make the patient dangerously uncomfortable, for impulsive feelings that will make him unpredictable, or for low control that will permit a sudden attempt. If the contact is too poor, one will want to know whether the patient will go out of contact and stay there comfortably, go out of contact but remain uncomfortable, or be half-in and half-out of contact. If he is uncomfortable and in much turmoil, it will be necessary to evaluate very carefully the amount of restlessness, impulsivity and control. If he is settled in a bizarre illness, there is less reason to suspect likelihood of suicide.

B. ENERGIES

The most important indicators of energy, in terms of suicide, are the Fm and mF scores, which are interpreted as restlessness or tension. If there are more Fm and mF than there are M and FM combined, this is to be taken very seriously when a suicidal mood has been established. If the reality contact is too good or too bad, considerable restlessness, in either case, would be a serious indication that the patient is uncomfortable.

Usually one finds low M in suicidal risks, so the presence of a high number of M (relative to the whole record and to the other energies) is one important resource against suicide. The writers saw one patient (non-hospitalized) who had every serious indication of being a suicidal risk, yet who had high M and high F%;

and this person not only lived through a most difficult situation but carried out heavy responsibilities. The M in this kind of case seems to mean the patient can think his way out of the situation, and has the mental energy to see it through to completion. The high F% will be considered later, for it is critical.

Often a patient with the suicidal or anti-life mood will show a flattening of his energies, indicative of the apathy and futility he is probably feeling, but it is very important to weigh the presence of even slight FM or Fm in such a record, which is probably a meager one anyhow. It takes very little energy in a person who has too good contact, dead feelings, and low control to mobilize him enough for suicide, as there isn't much that needs to be mobilized.

The absence of Fm and mF is a good sign in nearly every case, taken by itself, because the patient is probably not restless. But before this conclusion is reached, one would have to go through the other steps to make sure.

C. FEELINGS

Many of the feelings are shown by the concepts themselves, which give the more exact content of the feelings whereas the recap scores (FC′ through FK) tell how much emotional energy is invested in them. One can tell from the content that a patient feels sad. But how sad? One may know he is anxious and frightened, but how much so in relation to the rest of his personality?

One of the best resources against suicide is a wide range of feelings that are well controlled, indicated by scores in which form is of more importance than color or shading. If a patient has many feelings that are not impulsive, he should be able to respond comfortably to many aspects of his environment; and he should not be desperate. That is probably why suicidal patients almost never present such a picture. The less anxiety the better, which means the fewer k and K scores the better. Sensitivity, as it is used in reference to c scores, is usually a bad sign in a suicidal mood, because the patient is probably feeling sorry for himself in this state and will be easily hurt by any threats. A large amount of Fc in proportion to the other feeling scores gives the personality a weak or tender look that bodes ill.

Probably the most common mistake is to think that the absence of FC′ means the patient is not depressed. Actually the most de-

pressed patients will give either no FC′ responses or only one. Their feelings are really dead, or "abnormally devoid of feeling," as was mentioned earlier. (Such a patient, when asked if he is depressed, will often answer, "No, I'm not depressed, I just don't feel at all, I'm dead inside.") As these patients recover, one usually sees the reappearance of FC′ and other so-called pathological feeling scores, but it only means that these persons "can feel again."

The two most important feeling scores to watch for are the presence of C (usually as "blood") and that of Fk, KF, or FK. To the writers, even one C can suggest impulsivity, provided there is any physical energy (FM) or restlessness (Fm); and this is taken most seriously. Anxiety is reflected in the k and K scores (including FK, contrary to some opinion) and it adds to the picture of someone who is deeply uncomfortable in his present state.

D. CONTROL

Lastly, the percentage of F, and its quality are most important. If the form level is either variable or poor, the F% means nothing and one automatically distrusts the control. Assuming good form level, the F% is the final consideration, for it is the cement that can hold together a personality which is against life, restless, impulsive, and anxious. The combined presence of high M and high F% (40%—60% roughly in such records as these) is the best insurance the writers know against suicide. The higher the F% (good form level is still assumed), the more likely a patient can hold on. Patients who endure a psychotic depression without seeking suicide nearly always show the grim tenacity of a high F%. Psychoneurotics who persist as psychoneurotics show this also, as well as convalescent catatonics and those paranoid patients who can function with their suspicions still inside them.

E. COMBINING THE FOUR FACTORS

The patient reader will wonder what he will do with these odd pieces of information. They are the questions raised as one goes through the four successive steps and which there is an attempt to resolve by putting the personality together in the last stage of study. If statistically and sign-minded colleagues have not left before this, they are likely to when the attempt is made to coordinate this information into an understanding of what an unhappy personality will do about his unhappiness. There is still

no short cut. It is necessary to think the person out on his own terms.

Probably the best way to demonstrate this is to build up a patient's personality from the recap. Presented in the following are summaries of the reasoning in three different cases, along with their Rorschach recaps.

Case 1. The patient is a girl of 19. The protocol itself (which is not reproduced here) was full of intensely suicidal concepts, such as are given in the appendix (Table 4), so before the recap was studied, the authors knew the patient had the prerequisite mood for a "suicidal risk." Looking at her recap, their reasoning would go like this: She doesn't see much and what she does see isn't too popular, (3 P out of 11 R) and two populars are seen somewhat uniquely (+ 2 P). Furthermore, her reality contact is variable (2 minus, 1 odd). The content is extremely dull (91% A), but this is not organic dullness. Her contact with her environment is unreliable, one concludes. Her energies are high but of the wrong type. She seems quite restless (0+5 Fm) and the high number of FM to M (9 to 1) suggests more agitation than useful energy. The low M, in an intelligent girl, which she is, is a bad omen when she can produce the other kinds of energy. Her feelings are "dead." There is not one single primary color determinant. But there is an additional C′sym which is an indication of deep depression in the absence of any other color, and she has that crucial other color score, an additional C ("blood") which suggests impulsive potential.

Furthermore, her control is both of poor quality (because of variable contact) and is pathologically low (9%). This patient could release her energies in odd or unusual ideas, but she is not completely delusional; and, moreover, she is restless in this state; so delusions will not be the only answer for her. However she could easily be impulsive, has almost no control, and has no satisfactory outlet for her energy in her feelings except a desperate depression. She looks uncomfortable, anxious, restless, agitated, and the authors conclude she could make a sudden suicidal attempt. (This patient was acutely suicidal before, during, and after this Rorschach for a period of several months, and was diagnosed as schizophrenia, other types, depressed.)

Case 2. Another girl, also 19 years of age, presents a similar recap. Her concepts too were suicidal, although not so much so

Case 1

RORSCHACH RECAP

Name: (Female) Age: 19 Examiner: ..... Date: .....

Artifacts: (None) .....

R—11 P—3+2 O—

LOCATION			DETERMINANTS			CONTENT		
W	—	8	M	—	1	H	—	1
D	—	3	FM	—	9	Hd	—	
Dd	—		Fm	—	0+5	A	—	10
S	—		mF	—		Ad	—	
DW	—		F	—	1	Anat	—	
			Fdesc	—		Obj	—	
Total=		11	FC′	—		Na	—	
			C′F	—		Sex	—	
RATIOS			C′sym	—	0+1	Abstract	—	
F%	=	9%	F/C	—		Blood	—	
SumC	=	0	FC	—		X-ray	—	
W:M	=	8:1	CF	—		Map	—	
(FM+m):(Fc+c+C′)		=9:0	C/F	—				
A%	=	91%	C	—	0+1	Total =		11
M:sumC	=	1:0	Cn	—				
			Cdesc	—		SIGNIFICANT SIGNS		
NOTES			Csym	—		DW	—	
			Fc	—		Contam	—	
			cF	—		Po	—	
			Fk	—	0+1	Do	—	
			kF	—		Persev	—	
			KF	—	0+1	Rejections	—	
			FK	—		Long RT	—	
						F Minus	—	0
			Total =		11	Total Minus	—	2
						Odd	—	1
						Confused	—	
						Vague	—	

as in Case 1. Briefly the reasoning here would be: Contact with her environment is poor, because of the low number of Populars, minus scores, perseverations, and confused, and generally vague, concepts. It can be seen from her concepts that she has the anti-life mood, and now it is apparent that she is thinking quite apart from the normal, more so than Case 1. Her content is perseverative on unusual ideas, suggesting a settled illness, and there is an anatomical preoccupation that looks pathologically high in such a meager record. Her energies show an encouraging amount of M (4), although she too looks restless (4 m) but most of these

Case 2

RORSCHACH RECAP

Name: (Female) Age: 19 Examiner: ..... Date: .....

Artifacts: (None) .....

R—20+1 P—3 O—

LOCATION			DETERMINANTS			CONTENT		
W	—	4	M	—	4	H	—	4
D	—	16+1	FM	—	2	Hd	—	
Dd	—		Fm	—	3	A	—	7
S	—		mF	—	1	Ad	—	2
DW	—		F	—	9+1	Anat	—	4
			Fdesc	—		Obj	—	1
Total =		20+1	FC′	—	1	Na	—	1
			C′F	—		Sex	—	
RATIOS			F/C	—		Abstract	—	
F%	=	45%	FC	—		Blood	—	
SumC	=	0	CF	—		Ink	—	1
W:M	=	4:4	C/F	—		X-ray	—	
(FM+m):(Fc+c+C′)	=	6:1	C	—	0+1	Map	—	
A%	=	45%	Cn	—				
M:sumC	=	4:0	Cdesc	—		Total =		20
			Csym	—				
NOTES			Fc	—		SIGNIFICANT SIGNS		
			cF	—		DW	—	
			Fk	—	0+1	Contam	—	
			kF	—		Po	—	
			KF	—		Do	—	
			FK	—		Persev	—	3
						Rejections	—	
			Total =		20	Long RT	—	
						F Minus	—	
						Total Minus	—	2
						Odd	—	
						Confused	—	1
						Vague	—	4 plus generally vague

energy scores were weak when the concepts were re-examined. There is a lack of physical energy (2 FM) which suggests she might appear rather apathetic if one thinks of the 4 M as going into unusual ideas and the Fm as giving her a rather tense but not agitated picture. (A patient can be tense but still look apathetic because one can sit in one spot for hours, be tense, but do nothing.) The weakness of motion in the concepts themselves reinforces this notion. Looking at her feelings, one discovers that she apparently hasn't any. There is a lone FC′, which in the ab-

sence of any other color suggests a depressed state, and some anxiety (0+1 Fk)— and, again, that 0±1 C which in this case is a reference to "ink splotched on a blotter" on Card X. This C is not at all the explosive C of "blood" in Case 1, but more a weak and inadequate response to color as color. Now one may add the fourth factor, control, which is also of poor quality as in Case 1, but considerably higher.

It is concluded that Patient 2 is not suicidal, whereas Patient 1 is, and yet their recaps resemble each other rather closely. Why? Because, although both are against life and both depressed, Patient 1 is impulsive and more energetic in her hatred for life, whereas Patient 2 looks apathetic (low FM and weak concepts); has much less impulsive potential (C for "ink"); has higher control; and seems more out of contact. One might guess that Patient 2, although hating life, will seek a passive solution such as withdrawal, apathy, or perseverative delusions. Patient 2 has a settled look which Patient 1 lacks. It might be guessed also that the anatomical concern is a major content in her illness. (Patient 2 was considered schizophrenic, simple type, suffering from anorexia nervosa. She was described as a "placid, sweet, obedient" girl who became self-depreciating and felt she was "no good," but denied having any suicidal thoughts. She presented a clinical picture, at the time of testing, of apathy, tension, and gradual loss of interest.)

Case 3. The third case is that of a 61-year-old man who gave but six responses; but these responses showed a suicidal mood ("dead bat, stuffed animal, nightmare"). Many Rorschach clinicians might feel the record is too meager to evaluate; but the writers do not feel so, for it is a classical picture of a psychotic depression. Its brevity and rigidity are as diagnostic as any other sign. This particular gentleman had, we thought, the suicidal mood, so it was necessary to evaluate the recap in terms of what he was likely to do about it. On the recap, one sees good reality contact, good form level—almost too good in the sense described earlier. The contact however is pathologically small (6 R), for this is one of those patients whose illness will not let him see the forest for the trees. It is as if the camera shutter had been stopped way down and only a little light comes through. His energies are very low (1 M, 1 FM), and there is no restlessness (no Fm). Feelings are almost dead, except for 1 C/F ("colorful ocean bottom") on Card X which

Case 3

RORSCHACH RECAP

Name: (Male) Age: 61 Examiner: ..... Date:.....

Artifacts: .....

R—6 P—5 O—

LOCATION		DETERMINANTS		CONTENT	
W	— 5	M	— 1	H	— 1
D	— 1	FM	— 1	Hd	—
Dd	—	Fm	—	A	— 3
S	—	mF	—	Ad	— 1
DW	—	F	— 2	Anat	—
		Fdesc	—	Obj	—
Total =	6	FC′	—	Na	— 1
		C′F	—	Sex	—
RATIOS		F/C	—	Abstract	—
F%	= 33%	FC	—	Blood	—
SumC	= 1	CF	—	X-ray	—
W:M	= 5:1	C/F	— 1	Map	—
(FM+m):(Fc+c+C′)=1:1		C	—		
A%	= 66%	Cn	—	Total =	6
M:sumC	= 1:1	Cdesc	—		
		Csym	—	SIGNIFICANT SIGNS	
NOTES		Fc	— 1	DW	—
		cF	—	Contam	—
		Fk	—	Po	—
		kF	—	Do	—
		KF	—	Persev	—
		FK	—	Rejections	— II, IV, VI and IX
		Total =	6	Long RT	—
				F Minus	—
				Total Minus	—
				Odd	—
				Confused	—
				Vague	—

is a rather innocuous feeling-response, and 1 Fc ("mottled pelt") which was the Popular on VI. Control is high (33%) and of excellent quality. It was concluded this patient was not likely to commit suicide at the time the writers saw him, because he appeared relatively comfortable and set, in his depression. There is no restlessness, no impulsiveness, no anxieties. However he is deeply depressed which the absence of FC′ does not disprove. This is the cold, hard Rorschach recap of a deep depression in which there is no movement. The recap describes a state of personality that is as close to being dead as anything we know—slow pulse,

cold to touch, barely breathing. This, the writers think, is the sort of patient who will choose the depression itself, rather than suicide, and will endure a long period of it without harming himself. (This patient had a clinical diagnosis of involutional melancholia whereas the writers saw him as a manic-depressive, depressed, type.) He had been depressed on and off for about two years before being hospitalized, at which time the writers saw him. Clinically he was depressed, retarded, and hypochondriacal, and was said to have had suicidal thoughts before admission. The patient said, "I am sad, just numb, just neutral, like hit on the head. I'm not suicidal. I want to die. There is no sense living on this way when it's hell day and night." This patient was in the hospital for a year, showed no suicidal behavior during that time, got well slowly and left much improved. To the writers, he was an example of the depressed patient who will endure a long depression without ending it by suicide.

These cases are few, but they may help other workers who wish to try out this technique. The basic reasoning is the same in other types of suspected suicidal patients.

After seeing these many suicidal patients, the writers, of course ask themselves what makes a person commit suicide? How must persons feel to want to take their lives? There are many theories and much discussion of symbolism, but from what can be seen on the Rorschach, the writers believe that these people are simply sick of struggling with life, not fascinated with the meaning of death, or its symbolism. They can see no answer, no future happiness in life. The world to them is a dismal, frightening, hopeless place; and to go on living means being tense, afraid, useless. They turn to death simply because life is no longer worth while to them on their terms. Death is probably not attractive, and probably presents a conflict too; but, at least, whatever death may be, it is cessation from the present strife, defeat, and discomfort. Suicide may be accomplished in anger, or out of resentment, or out of hopelessness, or in a panic, but the patient is angry at life, resents life, feels hopeless about living, or fears it. It is the attitude toward life, not toward death, that, the writers think, determines whether a person will consider suicide.

Summary

A technique for detecting "suicidal risks" on the Rorschach among hospitalized psychiatric patients has been described in

terms of mood (content) and theoretical interpretation of scores. It is maintained that the whole patient "must be thought through" in terms of his own personality before a decision can be reached. Of the 105 patients (out of 1,250) so detected, 77 per cent showed adequate clinical evidence of suicidal intent. Conversely, in another and smaller sample, about 70 per cent of the patients who were clinically suicidal were picked up by this technique. The technique is defined within certain strict criteria and for the population used.

Table 4—Appendix—List of Suicidal Concepts

1. Concerning death, sickness, decay, stone, ice, or aging

Card I	Skull, human bones, sarcophagus, prehistoric, drab.
Card II	Death mask, icicles, skeletons.
Card III	——
Card IV	Disagreeable limp worms, goat skull, the way a dead bird's neck hangs.
Card V	Old men going to sleep or sick, the representation of death that swoops down and smothers or crushes life out of things, some dead animal.
Card VI	Ice or stone formation, snow or chopped ice.
Card VII	Burnt parchment, icicles or snow, back to my depression again because they all look like skeletons, drop of water that froze before it had a chance to become an icicle, man with a vacant stare who might be dead.
Card VIII	Moldy stick as if it had been floating quite a while, bony structure.
Card IX	Two old monks, two Egyptian coffins, stone walls, like a cancer growth, rust stain, snow on top of a mountain, pressed flower that looks faded, stone image, feeling of cold stone, rock formation, an hour glass.
Card X	Pair of diseased lungs, very faded rabbit's head, skull-like African thing, distorted view of a sick body, stone images.

2. Mutilated, missing, bloody, deformed

Card I	Cut off, headless, bloody, squashed, deformed, mashed torso, jagged.
Card II	Womb with blood running out, blood smear, splashing blood, figure who has lost a nose in a struggle, blood-looking picture, bloody stumps of a wrist

amputation, blood splattered on cotton, caterpillar someone has stepped on, dog collar but empty space where license should be, splashes of blood, pools of blood.

Card III — Frog cut in half and bloody, half of a body of two dogs, red lungs of a chicken that's been cleaned, spots of blood running off, pools of blood.

Card IV — Animal skin split up the back, two newborn puppies in their sacks and I'll cut them open.

Card V — Bat mashed with a broom, gruesome messed-up face, meat hanging in a butcher's shop, leg that's been smashed and mangled, quail that is dressed and ripped and backbone broken and ready to fry, alligator that was born blind, chicken legs.

Card VI — Bear split down middle and laid open, leg amputation, somebody skinned an animal.

Card VII — Moth-eaten scarf, grotesque stuffed animals, person dancing who is minus a leg and the head's off, rabbits whose arms look dislocated.

Card VIII — Gruesome animal formation, this is kind of a bloody looking one, spinal cord that has been cut, piece of paper torn half way through.

Card IX — This is a bloody one, somebody's throat cut open, somebody's guts all laid out, lobster with a claw broken off, badly botched floral display.

Card X — Two mongolian idiots, unattractive bit of blood, plucked chicken ready to be roasted.

3. Anatomy

Card I — Pelvis, x-ray, vertebrae, specimen.

Card II — Pelvis, x-ray of huge ribs, end of a spine.

Card III — Vertebrae, pelvic bones, human embryo, lungs, rib section cut out, pelvis, medical illustration of thighs, joints, spine.

Card IV — Backbone.

Card V — Bones.

Card VI — Dark cross-section of skin under a microscope, inflexible fish bones, x-ray of lung, expanding lungs, animal backbone.

Card VII — Skeleton with chest and stomach, vertebrae, backbone, pelvis.

Card VIII — Diagram of an internal organ, skeleton of vertebrae, skeleton of abdomen, vertebrae, x-ray of ribs, skeleton bones, ribs, spinal column, backbone, skeletons,

red represents the mechanisms of life—the spine and lungs.

Card IX — Diagram of something internal, vertebrae, backbone, x-ray of the root of teeth, skull place where eye-socket is, partial bare and bony skull, spine.

Card X — Something internal, pelvic bones, vertebrae that's dispersed, the color of bile, lungs, pair of kidneys, what you see when you get ether, stomach, pelvis, spine, dilated vagina, end of a spine, skeleton.

4. Frightening, weird, grotesque, evil

Card I — Bloodsucking vulture, witches dancing, ghosts, false face of Hallowe'en, goblin, nightmare, freaky hobgoblin, little gnomes, fox's head with evil eyes.

Card II — Horrible face, horrible blot, Merlin, wizard, Hallowe'en costumes, mosquitoes injecting malaria into body.

Card III — ——

Card IV — Jaggy and not very pretty bat, devil's or demon's head, weird Mephistopheles looking down, vampire bat, big broad gorilla, nightmare character, frightening ocean monster, some horrible monster, grotesque gray shadows.

Card V — Mephistopheles, snapping alligator's jaws, devil's profile.

Card VI — Goddess of evil sitting up with swords sticking out of her, long round eel or snake that's alive, reptile and I'm deathly afraid of them, clownish scorpion, tiger's hide.

Card VII — ——

Card VIII — Ku Klux Klan men or ghosts.

Card IX — Awfully evil monstrous man with weird and scary eyes, evil looking old man.

Card X — Two horrible arguing bugs, heads of dinosaurs, two dragons, hydra, a nightmare of insects, bandit with handkershief drawn over his face, gremlins.

5. Falling, hanging, taut, suspended

Card I — (Objects) spread out, tacked up, taut, clouds moving before a storm.

Card II — ——

Card III — People skating and they'll fall, butlers pulling and about to fall, two naked women coming from the air on a trapeze, two figures falling head first.

Card IV	Two people hanging onto something, protruding eyes of a shellfish as though they were hooded or on stilts, tree hanging over a cliff, hide nailed to wall.
Card V	Something pressed down.
Card VI	——
Card VII	——
Card VIII	Two rats hanging on two trees, snails hanging on by suction, animals going to fall and clutching and it's a very dangerous feeling, flower petals falling.
Card IX	——
Card X	Two old ladies in rocking chairs almost falling over, goats falling through midair, queer creature trying to step off something, balloons on a string, clouds floating in the air, towels hung up and blown, people hanging down and holding hands.

6. Dark, murky, foggy, shadowy, cloudy

Card I	Shadows, at night, black against clear sky, dark, grayish, silhouette in the dark, shades of dark.
Card II	Murky background, shadowy bears, red and black ink, inkblot.
Card III	Everything double and black, floating black pieces of filmy gray cigarette smoke, red coral and black.
Card IV	Mist, storm clouds, cloudy bull's face, shades from black to light gray.
Card V	Murky looking bat, bat flying at night against a clear sky, black butterfly, shading from black to gray, inkblot.
Card VI	Black and gray shades.
Card VII	Naked person standing in the dark, cloud, someone shrouded in black and coming out of a cave, cloud formation, shading from black to gray.
Card VIII	Dark gray I'm sad to say, clouds during a thunderstorm.
Card IX	Shadows of two cats' heads, cloud of the atom bomb, shadow of somebody, shadow of a flame, puff of rising smoke, spirit of the universe related to clouds, cloud reflection, something spongy from the sea.
Card X	Black seed pods, cloud.

7. Aggressive, explosive, destructive

Card I	Animal ready for a fight.

Card II	Bears fighting (suggested by red color), fire in the wild red, bears that have been shot, fighting dogs who've gotten blood all over, tusks, two things fighting, fire.
Card III	Cannibals stirring a pot, fire burning in center of a room, red flame.
Card IV	Smoking tree or fire.
Card V	——
Card VI	Two people fighting, flying ducks that have been shot at, toaster when you open it up.
Card VII	Belligerent ladies, two people gazing at each other with hatred too deep to express, couple of indignant people.
Card VIII	Fire tongs, bullet streaming along, red lion standing over blob of something he has just killed and about to eat up.
Card IX	Billowing atomic bomb with the red meaning destruction, two people with swords fighting one another, lamb kidney that I have just skinned.
Card X	Green squashy caterpillars that attack the trees, insects eating the trunk of a tree, two creatures going at each other, two snakes eating the eyes out of a rabbit, snakes with half of them hacked off, everything here looks as if it's attacking or feeding off of another, firecrackers after they explode, two unicorns coming around a pillar to fight each other, cannon pointing up in the air.

7. Passive, infantile, trapped, praying, sad

Card I	Being held, two hands in prayer.
Card II	Sad looking candy cane, hands clasped in prayer, hands tied together.
Card III	——
Card IV	Crucifixion, baby wrapped up in a blanket, weeping willows.
Card V	Pretty poor bat, moth resting.
Card VI	Bird with hollow eyes and staring with a hopeless expression.
Card VII	——
Card VIII	Weeping willow tree.
Card IX	Animals trying to break loose but it's futile as they're unable to escape.
Card X	Angels flying, lily, fetus getting life out of the mother, two arms holding up a six-week embryo.

9. Changing, restless, balancing, running.

Card I	Whirling (figures).
Card II	Movement in this black.
Card III	Princes turned into frogs.
Card IV	Old maids whirling.
Card V	Rear of running animal.
Card VI	Waves breaking.
Card VII	Two dwarfs balancing on a stone, rocks balanced on each other, someone or something in motion, two dogs balanced on rocks.
Card VIII	White clouds moving behind the blue.
Card IX	Picture of the wind blowing.
Card X	Wind blowing the flame of a torch, pendulum swinging and weighing a balance, things of the sea going for the sake of movement and bumping with no intelligence or purpose, there's motion somewhere, pair of wild animals in flight.

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THE DISLIKE FOR SATIRE AT LENGTH

An Addition to the Theory of Wit

BY EDMUND BERGLER, M. D.

The modern reader does not only fail to understand satire, but withdraws from it as from an unpleasant experience. He is not only bewildered by it; he actually dislikes it.

HILAIRE BELLOC: *A Conversation with a Cat and Others.* Chapter XXIII, "On Jonathan Swift."

Belloc's utterance is entirely in accord with the balance sheets of publishers: Satiric books do not sell. The usual explanation for this is a rather "highbrow" one; the typical reader, it is said, does not understand satire.

But in utter contradiction to this is another, also undeniable, fact: The daily life of the average person is permeated with one or another form of satire, irony, "kidding." Why, then, are average persons unable to comprehend satire when it is presented in book form? Or, if they do comprehend it, why do satires in book form mean certain loss for the publisher?

To complicate matters further, a book written without touches of humor, irony and satire is almost invariably castigated as "pompous" and "boring."

The need for satire is obvious: The "funnies" included in virtually all daily papers are proof positive, and so are the immensely popular full-length comic books.

This puzzle of contradictions seems to offer no hope of solution, and it cannot be solved without considering three otherwise neglected factors, and their psychological interconnections. These factors are: the theory of wit and satire, the quantitative element in satire, and the unconscious meaning, for the reader, of the printed book.

I. THE THEORY OF WIT AND SATIRE

For nearly 50 years, the problem of wit has been viewed solely as a saving of psychic cathexis, a point clarified in Freud's famous book on wit published in 1905. This theory holds that re-

pressed tendencies are maintained in a state of repression by a certain amount of counter-cathexis; if, for a split second, this counter-cathexis becomes superfluous—the teller of the joke taking the "responsibility" for expression of the infantile forbidden—the change into explosive laughter is accomplished. All witticism—though this was never stressed *expressis verbis*—has an aggressive connotation (even including "sexy" jokes, since they transgress against the infantile prohibition); hence, there is the inescapable conclusion that the storehouse of repressed aggression contributes the raw material.*

In the writer's forthcoming book, *The Superego,* he contradicts this assumption, suggesting the theory that the raw material of wit is *psychic masochism, outwardly warded off with pseudo-aggression.* Briefly, Freud's original brilliant assumption is supported, but a deeper layer is added.

The differentiation between *real* and *pseudo*-aggression seems to the author to be of paramount importance for the understanding of human behavior. Confusing the one with the other leads to tragic errors in studying psychopathology. In the writer's opinion, *every* person emerges from the infantile stage with *some* remnants of masochistic tendencies. To ward these off, use is made of neurotic pseudo-aggression, a defense designed to placate the inner conscience.

Without going into the details of the genetic and clinical pictures of psychic masochism (the writer has devoted a long book, *The Basic Neurosis,* to this topic), the author would like to express his conviction that the greatest danger in life is the placating of these undigested psychic masochistic components. He believes that *the real stasis of the "inner self" is NOT relentless inner aggression, but relentless inner masochism.*

For practical purposes, the accompanying table summarizes the differences between real and would-be aggression.

Applied to the problem of wit and satire: It is exactly the overflowing storehouse of psychic masochism, counteracted by reproaches of the unconscious conscience, which provides the ever-ready trouble. And the ever-ready alibi is pseudo-aggression. The defendant's formula is simple: "How can I be accused of masochism; see how aggressive I am!"

*Witticism should be distinguished from "grim humor"—in the latter the "expenditure of pity" is saved (Freud).

Differences Between Real and Would-be Aggression

Normal Aggression	*Neurotic Aggression (Pseudo-Aggression)*
1. Used only in self-defense.	1. Used indiscriminately when an infantile pattern is repeated with an innocent bystander.
2. Object of aggression is a "real" enemy.	2. Object of aggression is a "fantasied" or artificially-created enemy.
3. No accompanying unconscious feeling of guilt.	3. Feeling of guilt always present.
4. Dosis: Amount of aggression discharged corresponds to provocation.	4. Dosis: Slightest provocation—greatest aggression.
5. Aggression always used to harm enemy.	5. Pseudo-aggression often used to provoke "masochistic pleasure" expected from enemy's retaliation, or to refute inner conscience's accusation of masochistic passivity.
6. Timing: Ability to wait until enemy is vulnerable.	6. Timing: Inability to wait, since pseudo-aggression is used as defense mechanism against inner reproach of psychic masochism.
7. Not easily provoked.	7. Easily provoked.
8. Element of infantile game absent; no combination with masochistic and *defensively* "sadistic" feelings; the only feeling is that a necessary though disagreeable job has to be performed.	8. Element of infantile game present, combined with masochistic and *defensively* "sadistic" excitement, usually repressed.
9. Success expected.	9. Defeat unconsciously expected.

*First published in Quart. Rev. Psychiat. and Neurol., 1:1, 1946.

Investigators have always been puzzled by the fact that a joke loses its point—even when the "plot" is scrupulously preserved—as soon as it is stripped of the mechanisms of allusion, condensation, displacement, substitution, hint, psychic shift, projection, exaggeration. To exemplify: Fred Schwed, Jr., wrote a hilarious Wall Street satire based on an old joke about two newcomers to New York whose sightseeing tour of the town included that stretch of the East River where Wall Street's bankers and brokers moored their yachts, and who then asked, "Where are the customers' yachts? When the condensation is eliminated, and the story "rephrased," for example: "Because there are suckers who entrust their money to bankers and brokers for speculation, the bankers and brokers live a parasitic life of great luxury, while the suckers

lose their money," the joke evaporates, leaving at best a bitter accusation.

Every joke has as its pre-requisite the inclusion of a half-riddle to be solved by the listener. Without this touch of allusion, condensation, shift, substitution or displacement (as Freud originally pointed out), there can be only statements of fact, true or false. It is these unconscious mechanisms, visible in seemingly formal esthetic disguises, which account for that peculiarity, the witticism.

In short, without the half-riddle technique, no joke is possible. *This filling in of blank spaces is psychic work to be performed* by the listener, and, interestingly enough, is taken as proof of *activity.*

This point is the first in a series of six clinical facts upon which the writer bases the assumption that *only pseudo-aggression is released in the response to witticism.* To continue the series:

Second, the half-riddle technique of every witticism has an additional connotation: The child in the listener is *taken into the half-confidence of adults.* A joke activates the situation, consciously long-forgotten, in which questions were asked and replies postponed or refused. ("You will find out when you are grown up.") In the case of a witticism or a humorous anecdote, the narrator gives the answer, only thinly veiled, to the listener. This veil is now penetrated—the joke understood. But the child in the listener takes this thin veil as proof of his continuing need to outsmart the adult, who is still leaving the forbidden, as half-forbidden.

Third, the amount of information required in order to understand a joke proves to the child in the adult that he has *"mastered" all* (*sexual*) *riddles—actively.* Simply because it is a commonplace, and therefore nothing to brag about, this need for an extensive body of information is frequently overlooked. If we summarize the background of knowledge, conscious and unconscious, needed to grasp the point of the joke about the customers' yachts, a surprising variety of fields is represented: economics, the techniques of banking and brokerage, the high cost of yachting, etc. At the same time, there must be familiarity with the twists and turns of human behavior, awareness that the extent of self-deception in humans is limitless, or nearly so, that the sucker is not an innocent victim, but a gambler unconsciously seeking masochistic pleasure, and so on.

Fourth, the person listening to a good joke *behaves as if all of the afore-mentioned activities—solution of the half-riddle, being taken into the half-confidence of adults, and information-please mastery of knowledge of the forbidden type—were performed in the face of the educators' prohibition.* These educators are enshrined in the unconscious conscience. Therefore, paradoxical as this may sound, *the explosive laughter is directed at the inner conscience.* This was first stated in 1933 by Jekels and the present author in their joint study: Transference and Love, *Imago,* xx, p. 14. *The joke*—every joke—*is on the super-ego,* which thus becomes a figure of fun "in its own house." In effect, this laughter is the defensive triumph of the psychic masochistic part of the personality, through the use of pseudo-aggressive props.

Fifth, the child in the adult, although he plays the "big shot" and listens openly to a "forbidden" joke, is in reality trembling behind his mask of pseudo-aggression. Proof of this lies in the fact that in listening to the joke, he *shifts the responsibility* to the teller of it, his alibi being, "I didn't do anything wrong, I just listened. The joke-teller is responsible." Freud clarified this element of shifted responsibility in his original formulation; his formulation was enlarged later (Reik) by the explanation of why jokes must be told and not thought. And the presence of a third person distributes the guilt even more widely.

Sixth—last but not least—observation of circumstances lending themselves to joke production prove conclusively that pseudo- and not real aggression is at stake in witticism. In general, two situa-

*A sideshow concerning scopophilia has been adduced: In continuation of the Bergler-Eidelberg study on depersonalization ("The mechanism of depersonalization," *Int. Zeitschrift für Psychoanalyse,* 1935), in which it was shown that exhibitionism can be used as a defense against voyeurism, Eidelberg applied this idea to the psychology of wit ("A contribution to the study of wit," Psychoan. Rev., 32:1, 1945). In listening to a joke, the child in the listener is playing the voyeur; via identification with the narrator, voyeurism is transformed into exhibitionism. But this change is made under pressure of conscience, from which Eidelberg draws the conclusion that "deception of the super-ego is the condition *sine qua non.*" Otherwise, Eidelberg's and the writer's approaches to the psychology of wit differ both in conclusions, and in the reasoning leading to the conclusions. This is most marked in consideration of the defense against repressed psychic masochism. The point which in the writer's opinion is the decisive one, namely, taking the blame for the lesser crime (pseudo-aggression), is missing from Eidelberg's formulations. Eidelberg concludes that "exhibitionistic and aggressive pleasure from the satisfaction of aggressive and infantile instincts in laughter" is the motor of wit enjoyment.

tions are predominant: when the individual is unconsciously accused by the inner conscience of being afraid; and when he is accused, again by the inner conscience, of tolerating a consciously painful situation for the sake of masochistic pleasure. Confronted with the reproach of passivity, the inner lawyer (the unconscious ego) mobilizes would-be aggression as an alibi. The result takes two forms: *"jokes out of fear,"* or *"jokes out of being allegedly fed up."* In the first case, the lawyer's brief reads, "My client is not passively frightened, but actively above the situation." In the second case, it read, "My client is not passive-masochistic, but fed up with the situation, and even bored with it." In both instances, the core of the argument seems to be that a joker, or a bored person, is active.

Poets have instinctively sensed this interconnection, although consciously they could not have known either cause or effect. The fear-joke is nicely alluded to in Lessing's "Not all are free who ridicule their chains"; the "fed-up" type is hinted at in Nietzsche's dictum, "Man alone suffers so excruciatingly in the world that he was compelled to invent laughter."

* * *

Jokes "out of fear" and *jokes "out of being fed up"* have one common denominator: Both are *alibis presented to the inner conscience.* The best defense being attack, the frightened child in the adult acts according to the principle of Marshal Foch: "My center is giving way, my right is pushed back: excellent; I'll attack."

This whole deduction will of course sound peculiar—to use an understatement—to the conscious minds of people unfamiliar with the world of the unconscious, and its rules. People believe that they are joking because they are in a gay mood; the idea of furnishing inner defenses in reply to a monster, conscience, never occurs to them. And when they are given the factual information that at least 50 per cent of the psychic energy of every human being is spent in presenting alibis and defenses to the accusing ogre of inner conscience, they just believe that "you are trying to pull my leg."

The same reaction comes when they are asked why they are laughing at a specific joke. After overcoming initial astonishment (why ask questions about the self-evident?), they answer, "I'm laughing because it's funny." When tactfully informed that the reply is meaningless, because redundant and tautological—"I'm

laughing because it's funny; it's funny because I'm laughing"—the proverbial shrug of the proverbial broad shoulders rings down the curtain on the proverbially bright argument.

And if one insists that there must be some differentiation among these large areas of what is considered "funny," since it is undeniable that some people laugh at some jokes, and some at others, this pat reply is usually forthcoming: "The fellow who doesn't laugh at the jokes I consider funny just has no 'sense of humor.'"

And if one commits the sacrilege of pursuing the matter still further, and of asking for a definition of the term, "sense of humor" the answer is clear-cut: "Don't be a pest; sense of humor means recognizing when something is funny." And "funny" is what makes you laugh, because it is—funny.

Freud pointed out that when people laugh at the same joke, they are proving the inner proximity of identical inner conflicts. The development from crude jokes of the hitting variety to "psychological" jokes marks the development from the simpler to the more and more complicated defenses.

Obviously, it is unfair to pursue this line of questioning with the uninitiated; people do not know why they laugh, simply because laughter and jokes have a complicated inner substructure. And this inner, hence unconscious, substructure, is simply—unconscious. And the term, unconscious, means but one thing: complete conscious ignorance.

To start with "jokes out of *fear*." Intuitively, some severe masochists do on occasion get an inkling of what this is about. The poet Heinrich Heine confessed:

In jenen Naechten hat Langeweil' ergriffen
Mich oft, auch Furcht—nur Narren fuerchten nichts—
Sie zu verscheuchen hab' ich dann gepfiffen
Die frechen Reime eines Spottgedichts.
(*Romanzero, II; Lamentationen, "Enfant perdu"*)

No translation of this stanza is available; loosely translated, it means: "In these nights, boredom gripped me, and so did fear—only fools fear nothing—; to counteract fear I whistled the impudent stanzas of a satiric verse."*

*It is impossible to understand how Heine was able to express this intuitive perception, except through studying this poet's masochistic regression. See *The Writer and Psychoanalysis*, and *Money and Emotional Conflicts*, Chapter "Dependee," (Doubleday, 1950 and 1951, respectively).

A physician who later achieved renown as a pathologist reported that he lived through the "strongest fear of his life" when applying for the position of assistant in a pathological institute at a foreign medical school. The cause of his fear was the reputation of the chief pathologist, a man of intimidating personality as well as a recognized authority in his field. This man was notorious for the sarcastic criticism which he freely bestowed on his subordinates; to enlarge his opportunities for criticism, he subjected his staff to frequent extracurricular examinations.

The young physician who later became the writer's patient was told to perform a complete autopsy, according to specific rules established by the professor. The vigilant eye of the professor followed every move, but all went well until the bladder had to be removed from the body for inspection. The young physician's technique was too forceful, and the bladder burst, spattering everyone around the table with the dead man's urine. The professor, faithful to his joke-motto—"Anger will not do, irony is the only thing"—was at the point of opening his mouth to express his derogatory opinion of the young man's technique when the culprit anticipated him by stating ironically, "Well, at least my mishap achieved one result—it proved that dead men can urinate." The professor laughed and said, "That's exactly what I was about to say." And to take revenge on the "wise guy" the professor added, "Perhaps you should apply for a job as mind-reader; as pathologist you are not so good."

Without going into the complicated network of what the young physician unconsciously projected upon the professor, what dissecting unconsciously meant for him, and whether the "mishap" could have been avoided, the fact remains that he was scared stiff. The super-ego reproach, usually evoked by misfortune, "This can happen only to you, you passive weakling," was personified in the malice of the professor, who was in the habit of crediting *typical* mistakes to *individual* and exclusive incompetence. Moreover, there was good reason for the assumption that the young man provoked the incident in the first place, in order to be verbally castigated (castrated) by the big shot. In any case, the witticism he produced was a defensive one.

A well-known writer told the author a story dating from his journalistic past, when he had been assigned by his newspaper to witness an electrocution. The condemned murderer, sitting in the

chair, watched the executioner's not too calm handling of wires and electrodes, and remarked, "What's the matter with you, *you* are nervous?"

One could object that not all situations preceding the production of jokes are so dangerous and forbidding as the examples cited. Of course they are not—*inner* fear substitutes for the external danger. And to complicate matters, *the fear-sufferer* (department: inner fear) *must be entirely unaware of his fear—consciously.*

Jokes of *"allegedly being fed up"* presuppose an endlessly protracted, painful or humiliating situation, once more misused by the super-ego, for the purpose of torturing the victim. The defense is, "I am not getting masochistic pleasure from the humiliation, I am bored with it, and even joke about it."

For decades, an old man endured his wife's liaison with her lover; he never effectively broke up the triangle. When the ironic question, "How is X. (the lover) getting along?" was put to him, he replied, "I haven't seen him for a long time; I am in contact with him only through the newspaper." "How so?" "Well, I check the obituary column every day to see if he has died."

The satiric poet Heine was paralyzed during the last decade of his life, suffering from a disease which has never been clearly identified (probably tabes, a late sequel of syphilis). When someone asked how he endured his suffering, he replied that God had sent this visitation to him only to prove that He is a better satirist than Heine himself. . . .*

* * *

Jokes, therefore, have an inner connection with passivity, and represent alibis of a specific sort disproving the accusations of conscience.

II. Four Unconscious Meanings of the Quantitative Factor in Satire

It is exactly the psychic work necessary in order to grasp the meaning of the ironic, satiric or witty utterance which accounts for both the deep satisfaction of the listener, and his limited ability to solve such "riddles"—if they are presented *en masse.* The

*Not all people are capable of producing jokes; those who cannot are magically attracted to, and repeat, jokes of the specific variety which pertains to their specific inner conflict.

listener (or reader) can take only a limited amount; beyond this, he "gets tired." Jokes, satire, derision, can therefore be taken only in small doses.

This in itself counteracts the effect of satire, when it is made the sole basis for an entire book. Looking through successful satiric books, one finds that their authors have intuitively taken this factor into account, and make use of two technical devices in order to get around the barrier of quantitative limitation. The successful satirist will either limit himself to a single theme, and fill his book with elaborations on it (e. g., *Gulliver's Travels,* or more specifically, "A Voyage to Lilliput," the only section of the book to become a "familiar" classic), or mingle his satire with enough love-interest, or other non-satiric elements, to divert the reader (e. g., Wakeman's description of the soap magnate in *The Hucksters*). The juxtaposition of Swift and Wakeman is also to the point, because Swift—a master—shows how it should be done, whereas, if one takes Wakeman's inept love-story into consideration, his book becomes an example of how full-length satire should *not* be done.

The most brilliant modern example of bitter satire which was piled too high and therefore failed to achieve popular success is Charles Yale Harrison's *Meet Me on the Barricades.*

Satire, therefore, is "internal medicine" which the reader can swallow in homeopathic doses only. As soon as the allopathic dose is presented, it is rejected by the reader's unconscious.

However, these quantitative limitations also have other contributory factors. If the basic assumption is correct, and satire and derision are a frightened, unconscious slave rebellion by the fear-laden child in the adult, then the old fear of retaliation must be present, too. It is. The small dose represents a furtive glance, rather than a long look, at the forbidden. Quantitative limitation of satire, therefore, is also some form of *captatio benevolenciae,* an alibi in itself.

So far, three results of the quantitative factor have been mentioned: deep satisfaction, psychic work under strong pressure of guilt, and "the furtive glance" mechanism. The fourth link in this chain of active half-daring, and three-quarters passive scaring, is the alleged stupidity of the reader, "who doesn't understand satire."

The inability to understand satire is not a problem of low I. Q., but of fear. It is true that satire exists on different levels, the

lowest being represented by the "funnies," the highest (allegedly) by *The New Yorker* magazine. Nearly half a century ago, Freud pointed out that a common bond links people who laugh at the same jokes. Still, in the majority of cases, "lack of humor" is a neurotic phenomenon based on infantile fear which has not been overcome. The person who "doesn't understand" satire and wit is inwardly a child so frightened that he does not even allow himself the "furtive glance" at the forbidden.

III. The Unconscious Meaning of the Printed Book

As pointed out in *The Writer and Psychoanalysis,* the respect which the average person has (admittedly or not) for the *printed* word stems from the undigested fact that books are handed down to the child by people in authority. Moreover, for the first four to six years of the child's life printed matter is an "adult mystery," which puts it automatically into the category of things to be respected.

The typical reader of books (virtually an anachronism today, if one is to believe publishers aggrieved at television, radio and magazines) wants to be "entertained." This has led some writers to the conclusion that the purpose of art is "to please" (Somerset Maugham). This consideration applies to the hackwriter, however, and not to the creative writer, who writes because of the inner need to get rid of an inner conflict by way of the sublimatory medium of writing. (In the book on writers, the author defined creative writing as "self-curative alibi-sickness.") The *quid pro quo* leads to frequent grotesque misunderstandings between writer and reader. In any case, the reader wants—by means of conscious and unconscious identification, although he is not aware of the latter—to enjoy his unfulfilled narcissistic, libidinous, aggressive hopes, his all-too-real, though unconscious, masochistic suffering, or his badly-needed alibis. Whatever the case may be, he wants to be taken very seriously. But satire does exactly the opposite thing. The strange fact is that "reader's identification"—the essential pre-requisite for "interest" in a book—counteracts appreciation of satire: The reader (once more without awareness) identifies *also* with the butt of the irony, and, to quote Belloc again, "is bewildered" and "actually dislikes it." Again, masochism victorious!

* * *

All these factors, taken together, explain why satire *in book form* cannot achieve popular appeal—it never did.* Satire has been and will be confined to the short-short: to the satiric sketch and the satiric poem. Shakespeare's dictum, "Brevity is the soul of wit" (*Hamlet* II:2, l. 90) applies to satire as well. For most people, it is a dish causing mental indigestion (fear!)—if consumed in more than minimum quantities.

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*The writer has deliberately omitted consideration of the problem of the satiric writer's mental-psychological inner equipment; it is dealt with in the study, "Anxiety, 'feet of clay,' and comedy," Am. Imago, 6:2, 1949. Also omitted is the problem of satire directed against *oneself;* for a discussion see the author's book, *The Battle of the Conscience,* pp. 172-189 (Washington Institute of Medicine, 1948).

THE VALUE OF MUSIC IN THE SUCCESSFUL PSYCHOTHERAPY OF A SCHIZOPHRENIC PATIENT*

BY PAUL WENGER, M. D.

Modern psychiatric trends have shown a tendency toward condensed, that is, briefer and more efficient, methods in the treatment of schizophrenia. Drastic somatic procedures,[1] such as the various shock treatments or brain surgery, have been combined with briefer psychological methods of individual[2] and group therapy[3] to combat this most common psychosis. In addition, "nonverbal" treatment methods, such as manual occupation, including the fine arts of painting,[4] and music,[5] have been stepped up greatly.

Generally seen, psychiatry in its course during the past 50 years has shown increasing interest in the patient's cultural[6] and social setting (Freud's "super-ego"; Adler's "social interest"; Jung's "collective unconscious"; Sullivan's "interpersonal relations"; Meyer's "common sense" psychiatry). At last the combined psychological and physiological approach,[7] including environmental as well as constitutional factors, seems to emerge as the most promising trend in psychiatric research.[8]

This writer, recalling his own interest in performing on musical instruments, introduced music therapy at one of the Veterans Administration hospitals in 1948 and observed its effect and results on psychotic patients during two years of experimentation. Individual and group application of instrumental and vocal music were studied. Approximately 10 per cent of all the hospital patients professed interest in practising some form of music; of this group, 50 per cent preferred popular to classical or jazz music; 40 per cent expressed the desire to play the piano rather than any other instrument; 30 per cent preferred singing to playing an instrument. Among the reasons given by these patients for their interest in the hospital music program, was relaxation with ensuing happiness and a feeling of encouragement.

A special psychiatric study made at that time comprised a group of 15 chronically-ill schizophrenics who, compared with a control

*Reviewed in the Veterans Administration and published with the approval of the chief medical director. The statements and conclusions published by the author are the result of his own study and do not necessarily reflect the opinion or policy of the Veterans Administration. This paper was prepared while the author was stationed at the Veterans Administration Hospital, Bedford, Mass.

group of 15 similar patients, were exposed to a weekly, recorded-music program; no psychological or physical therapy was applied during the experiment, which continued for one year. The result was definitely encouraging. At least half of this group—most of them having been sick from five to 10 years—became more rational and co-operative, so that they could be transferred to a better hospital ward after an attendance of no less than six months. A remarkable observation was the fact that vocal music (personality factor) acted upon the patients far more effectively than instrumental; popular and familiar tunes apparently brought out helpful associations and memories.

Illustrating the author's experience with music therapy, the following case of a World War II veteran, twice admitted to a neuropsychiatric veterans' hospital and now well-adjusted, is presented. The case lends a good account of the variability of mental sickness. Progressing from a picture of a catatonic schizophrenic reaction, through paranoid features, to an obsessive-compulsive state with hysterical manifestations, and tapering off as an anxiety reaction, the patient is one who has had no shock treatment, but mainly psychotherapy, individually and in a group, also in combination with sodium amytal medication. The case, furthermore, involves the use of music as a decisive therapeutic agent and finally brings in religion as a spiritual factor molding the life of the patient.

Case Presentation

Ernest T., a 29-year-old New Englander of Italian parentage, with no incidence of mental disease in his family, had all his life been strongly attached to an overprotective emotionally unbalanced mother. Preferring the passive role of an observer, he always wanted to please his parents. In society he was known as a good mixer, though somewhat shy; he liked female company, but had never been in love. On two occasions he had had intercourse with prostitutes. After two years of military service in the United States, he returned home to civilian life at the age of 22; yet this did not satisfy his emotional needs. Ernest had met an apparently resolute—but in sentiment somewhat fickle—girl who, after a short courtship, pressed marriage, a situation for which Ernest was wholly unprepared, both emotionally and economically. This acquaintance soon became a source of intolerable tension. He felt unable to decide in minor matters, had difficulties in thinking, and

life seemed unreal. He was directed to seek admission at the nearest Veterans Administration hospital, a year after discharge from active military service.

Obviously Ernest, a devout Roman Catholic, had felt the sinfulness of his sexual response. At the hospital he became more encapsulated in a kind of rigid attitude and was diagnosed schizophrenic reaction, catatonic type. He remained preoccupied—sitting around, pulling tufts of hair from his scalp. At the height of his confusion, he made an awkward suicidal attempt by slinging a pair of socks around his neck. Religious thoughts were coloring the mental picture.

In time, Ernest improved to such an extent that he was discharged on trial visit to his parent's home after 18 months of hospitalization. He first seemed to be relaxed and fairly satisfied but then again began to be preoccupied, accusing the hospital doctors of having ruined his life. After a year's trial visit, he was referred to a nearby Veterans Administration mental hygiene clinic for further treatment.

The psychological treatment in the mental hygiene clinic for approximately a year consisted of non-directive psychotherapy. Yet, Ernest became hallucinated, hearing voices which would threaten physical harm to him. A friendly priest tried to explain to him that he was ill and not a sinner, but Ernest continued to have strong guilt feelings, being ashamed on the grounds that people would consider him "inferior."

During the treatment at the clinic, his first hysteriform attacks of unconsciousness occurred. Thus, he was building up an elaborate system of defense mechanisms. Another aspect of his split personality was expressed by the patient as follows: "One part of my person seems to be talking to me, telling me that I am bad."

Finally, Ernest was readmitted to the Veterans Administration hospital on a voluntary basis, approximately a year after his first hospitalization. At the medical staff conference, he was classified as a paranoid schizophrenic. He soon became more manageable, although his depressive features did not subside.

By that time it was observed that the patient was greatly moved by good popular music, that he became quiet and seemed relaxed. He presented an opportunity to test the assumption that auditory and visual perception play a far more important role in emotionally sick persons than is generally thought. Ernest had had no

previous musical training, but took with great interest to piano playing; he was instructed by a psychologically-trained pianist, who was volunteering her services at the hospital. He did amazingly well and was able to play light semi-classical pieces after two months of instruction. Even more remarkable, was his ability and tendency to express his inner feelings on the piano. The instructor suggested to him that he improvise tunes in accordance with his actual state of mind—an excellent method to relieve his inner tension and to abreact his confusion and anxiety. The patient would sit down, for short or long periods, during the day, pounding the keys or playing with only one finger, imitating stormy weather or gentle raindrops, whatever his emotions suggested at that time. He would make use of music as a therapeutic agent several times during the day; the piano was placed in a special room at his disposal. In fact, that period in Ernest's hospitalization was, in the writer's opinion, the decisive turning point which brought him back to reality. Although he afterward still underwent trying times, it seems that the approach through music enabled the author to break the deadlock and promote a strong positive transference.

Six months after the second admission, the patient looked more composed, walked more upright and behaved in a more co-operative manner. He came to the writer's office twice a week for individual psychotherapy, unraveling the tangled state of his emotional pattern.

Nevertheless, resistance manifested itself in the form of the hysteriform spells (screaming like a "caged animal"), which occurred with increasing frequency for weeks to come. When interrogated, Ernest described the spells as the result of his brooding over his past life. His thinking remained obsessive, guilt feelings continued undiminished.

On a Wechsler-Bellevue Test, he scored an I. Q. of 108. Projective tests confirmed the psychiatric findings. In that treatment period, the writer prompted Ernest to attend group therapy sessions and to give written expositions to the author on his religious beliefs. As he was devoutly religious, it was difficult to convince him of the idea that going to confession at this time would not relieve his anxiety, but would rather promote his guilt feelings. Another avenue of approach in the treatment was opened by suggesting sodium amytal interviews to the patient. By their use, many

gaps in his motivation, such as memories, former attitudes, and dreams were filled in.

Fourteen months after his second hospital admission, Ernest was presented to the staff. He made an excellent impression, performed freely on the piano and answered all questions rationally and to the point. The following month, the patient started to go on regular leaves of absence, attending dances with a neighborhood acquaintance. This new girlfriend offered to "go along with" his treatment. They became formally engaged in the 18th month of his second hospitalization. Ernest's attitude to marriage was expressed in several dreams. In the week prior to his discharge, he summed up his former experience and the insight he had gained from discussions with the therapist in these words: "I had a nightmare, I am now living my own life, not depending on parents, not feeling helpless; I like to meet people; I don't lose myself, I have a purpose in life." His newly gained attitude, based on self-confidence and religious belief, was vividly illustrated by one of his last dreams at the hospital: "I worked at a crossword puzzle; a few marbles fell to the floor, I picked them up and after various trials was finally successful in putting them together correctly; at this moment the marbles formed a brilliant picture giving the words, 'Our Lord.'"

Ernest was married in church in his home town, 20 months after his second hospital admission. He had been discharged from the hospital with some hesitation on the part of the medical staff. He was urged to visit an out-patient clinic for further advice in adjustment to community life and marriage, which normally requires a good deal of preparation.

A letter received from him after six months of married life stated, among other things: "I'm so happy. Now I agree with you that life is a battle, not a bed of roses."

One year later, the patient's wife informed the writer that her baby had been stillborn and that Ernest had "felt pretty bad" about it. "Otherwise," she wrote, "he has done very good, you wouldn't think he was ever that sick. He works every day and he is very easy to get along with." The patient himself added, in his most recent letter, after two years of community life: "I base my whole future on the foundation you have given me." He also informed the writer that he is now operating his own barber shop and is "feeling fine."

Discussion

Looking at the life chart of this patient, whose mental disease was apparent for seven years, one finds a history frequently observed in the formation of serious emotional disorders. Music was used to establish contact with reality and to develop a strong positive transference. Soon, resistance as a defense of his erroneous style of life developed. This made no allowance for independent action without the therapist at his side. After approximately 50 psychotherapeutic and narco-analytic treatments a reintegration of his personality was accomplished as seen in his successful marriage and satisfactory work record.

A few particular features regarding dynamics and the therapeutic setting of this case may be underlined: A gradual increase of disintegration became apparent as soon as Ernest left the protective atmosphere of parental or military supervision and was confronted with problems of sex and marriage. A strong religious reaction heightened his ambivalent feelings in these matters until he was engulfed in a sea of trouble, losing his common sense and reacting with a psychotic episode. Here one observes both unfavorable environment and inadequate personality make-up at work to knock him down. Only after he found his way back to the human community through music, through his therapist, his priest, and, finally, through his wife and family, did he become "his own-self" once again, rediscovering reality and, with it, a purpose in life.

The important roles of the medical and musical therapist's personalities were evident and were closely related to the problem of empathy. Equally, the environment into which the patient was released from the hospital played a most important part; in this case, the wife received helpful instructions in several interviews with the psychiatrist.

To find guilt-feelings in mental patients is an accepted part of therapy. And yet, there may not be too many case histories recorded in which guilt-feelings have persisted so intensely and permanently for years as in this patient. Here one may point to the widely-known interpretation of guilt-feelings as a portion of the resistance in the analysis of mental patients—caused by the patient's hostile and too severe super-ego. It seems, however, that guilt-feelings give the patient an excellent, though unconscious, excuse for preventing constructive action, thus revealing them-

selves as a neurotic symptom, giving the patient a position of moral superiority and showing his genuine lack of co-operation with, or interest in, his fellowmen.

This patient was remarkable as to his ability to improvise on the piano, an experiment suggested to him by the volunteer instructor. His first reaction was withdrawal, when he pointed to his big awkward fingers, which would lack the skill of mastering the piano keyboard. The instructor's insistence and interest in the set task, however, reassured him and enabled him to concentrate his will power, previously spent on his inner turmoil, on the useful composition of tonal pieces. These improvisations were at first dissonant though exact in their rhythm, depicting the cathartic emotional process at the start of the writer's treatment; later on, the playing became more consonant and harmonious, reflecting the synthetic aspect of his emotional reconstruction.

Music therapy is a part of occupational therapy and rehabilitation.[9] Music as an auxiliary therapy may hasten the recovery of *musical* mental patients, particularly music in the form of active participation individually or in groups—less so in passive form through listening. Opinions as to the best type of music to be used in the various types of mental disorders vary. However, it is known that slow, soft, string or wood-wind music has a sedative effect, whereas fast, loud, brass music has an exciting effect, on the patient. The timbre or tone quality is no doubt important, but is little understood. There are also suggestions that the mood and tempo of therapeutic music should correspond to the mood and tempo of the patient.

It is, furthermore, assumed that, by its nature, music works at the thalamic level rather than on the cerebral cortex,[10] a viewpoint that would lead to considering music a most suitable therapeutic agent for psychotic patients with their disturbed cortical functions. Also, there have been descriptions of how epileptic attacks may be induced by music (musicogenic epilepsy).[11] When used as an adjunct to group therapy of psychotic patients, the rhythm and melody of traditional or folk music gives noticeable results in the form of increasing group cohesion and better emotional integration of the individual personalities; the results suggest that a preliminary approach through music might facilitate other therapeutic methods in mental patients. A psychological analysis, inquiring why we love music,[12] enumerates five fundamental grounds:

physiological, perceptive, esthetic, social, and creative. Musicians[13, 14] have noticed that consonance resolves emotional tension, whereas dissonance produces tension. It is also felt that music therapists, in addition to their musical knowledge and training, should have some understanding of the patients' personality make-ups, to be of real help to them.

The healing effect of music, however, ought to be regarded as only temporary, though very helpful, in bringing a patient back to reality. It has its specific indications in artistically or religiously inclined patients. For such patients, music provides a social stimulus which should not be underestimated. Perhaps this process of "re-socializing" represents the essential value of music in the treatment of psychiatric patients.

Summary

Music therapy as a "non-verbal" treatment method is illustrated in the case of a World War II veteran suffering from a schizophrenic psychosis. It is pointed out that music, by its specific mode of perception and practice, has played a decisive role in the recovery of the patient, promoting a strong positive transference in an analytic treatment situation. The nature and healing effect of music therapy in mental patients is evaluated in general.

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AN EVALUATION OF DRAMA THERAPY

BY ALBERT A. KURLAND, M. D.

Introduction

Stimulated by the reports of Moreno and his co-workers[1,2] a drama group was organized at Spring Grove (Md.) State Hospital in 1949. It has been in continuous operation since, treating male and female patients with schizophrenic reactions. This paper attempts to report some of the experiences undergone and the problems encountered with this procedure in a state hospital setting.

A review of the literature in preparation for this study presented a rather puzzling paradox. Although drama group work is so suggestive of dynamic possibilities, it seemed to be stirring up very little response in the realm of therapy, as indicated by the paucity of records from either clinical or research standpoints. Recently, however, there has appeared an excellent review in *Occupational Therapy* by Dunton and Licht[3] on the various approaches by this method.

As a medium for seeing, experiencing and interpreting, with the formation of new integrations, the drama presents an inviting façade. As for its origin, history only tells us: "Drama begins with the dance before the dialogue; the play of body before the play of mind."[4] The very history of drama sharply silhouettes the changes in man, as indicated by changing dramatic values. Gradually, this same authority notes, the presentation of thought became as important as the representation of emotion, which was the main element in theatrical origins. "Indeed, in the first decade of the twentieth century the drama of the intellectuals definitely revolted . . . from the idea of 'four boards and a passion.'

"If we are to find a definition of drama that will cover all theatrical manifestations from the wordless ritual and mummery of primitive man to the actionless dialectic of a modern philosopher, that definition will be so loose as to be almost useless. It is more profitable to ask and answer two simple questions about the thing which is done. They are: "Why is it done, and how is it done?"[4]

Aristotle[5] in the fourth century B. C. was already a student of this problem and attempted to analyze the cathartic effect of the drama. The significance of this gap of 2,000 years until the pre-Freudian dawn has been discussed in great detail by a multitude of students and is outside the realm of this paper.

Two centuries prior to the dawn of modern dynamic psychology, Johann Christian Reil[6] in 1803 is said to have written: "Patients should be urged to portray scenes of their former life by narrative or acting them out." He also made the quaint statement, "Through the proper assignment of roles, other advantages could be gained such as ridiculing the follies of each patient." The unproductive effects of ridicule are only too well known today. Says Zilboorg of Reil: "He wanted to have a special theater in a mental hospital in which employees would play the roles of judges, prosecutors, angels coming from heaven, the dead coming out of their graves, which in accordance with the needs of the various patients should be played to produce the illusion of utmost verisimilitude." Wherever necessary, Reil held, prisons, lions' dens, places of execution and operating rooms, should be presented on the boards of this psychotherapeutic theater.

Whatever repercussions there were from this paper are not known. Apparently it made no deep impression. Nothing further is heard about this idea until the work of Moreno evolved in the twentieth century. In this same period, there was also the introduction of the epoch-producing formulations of Freud, and later of his students. Drama was once more re-examined in this newer light. The meaning of play became a little more clear. The Aristotelian terms "catharsis" and "abreaction" took on new meanings. New terms were coined to specify more clearly the various types of emotional reactions. The new concepts of the unconscious with the forces at work in it, such as repression, identification, exhibitionism and its relationship to magic, narcissism, masochism, the hidden meaning of fantasy, brought new psychological interpretation of the drama: "The Greeks, then, by presenting the possibility of dire consequence resulting from horrible incidents to an emotionally-tuned audience were able to develop ethical concepts in the audience. Immediate intolerable guilt feelings aroused by identification with the characters and action of the play were relieved by masochistic identification with the horrible endings."[7]

Writing in this vein, Freud,[8] in 1904, was presenting new formulations in the psychodynamics of drama and its relation to psychotherapy: ". . . the precondition for enjoyment is that the spectator shall also be neurotic." Neurotic in this case, refers not to psychoneurosis in the clinical sense, but to the degree to which repressing forces will permit identification of repressed impulses. Thus,

it is seen that one of the functions of the drama as a psychotherapeutic agent is related to its ability to promote spectator abreaction and insight. It is also a general psychoanalytical experience that the type of insight gained by an audience abreaction is rarely permanent, but at best is likely to be transient in character and followed by resistance or greater repression.

With these formulations and subsequent analytical investigations, there arose an awareness that being a member of an audience sets up a certain stimulus-response reaction in the unconscious; similarly, being an actor, being on the stage, and acting in the content of a play, all have unconscious factors peculiar to themselves. All this is masterfully delineated by Fenichel[9] in his paper "On Acting," which was drawn from his conclusions in studies of professional actors under psychoanalytic treatment.

In 1919 Moreno[1] began to speak of psychodrama and represented it as the chief turning point away from the treatment of the individual in isolation to the treatment of the individual in groups, from the treatment of the individual by verbal methods to the treatment by action methods. According to Moreno, features of the simplest psychodramatic technique are as follows:

> The simplest psychodramatic technique is to let the patient start with himself, that is to live through in a psychiatrist's presence, situations which are a part of his daily life and especially to live through crucial conflicts in which he is involved. He must also enact and represent as concretely and thoroughly as possible every person near him, near to his problems, his father, his mother, his wife or any other persons in his social atom. The patient does not represent roles in this phase of the treatment. It is not the father, the mother, the wife, or the employer; it is his father, his mother, his wife and his employer. The patient is aided by a member of the staff in getting started but the auxiliary ego remains outside the situation. The auxiliary may be outside the enacted situation but he is not outside the total situation itself. He is the theater and it is in front of him the patient acts. The tele relationship of the patient to his auxiliary ego has a definite bearing on the structure of the psychodramatic presentation. He watches the patient as he acts, encourages him and makes comments. At the same time the patient stops and explains his acts to him. The patient may act the same situation differently to a man and to a woman, to a person attracted to him and to a person indifferent to him.
>
> The presentation can relate to situations past, present or future. The patient is asked not merely to portray situations which he has lived, but to duplicate them completely. He is also asked to portray these situations with as much detail as possible, in collaboration with a partner if neces-

sary. If he is in the situation, a lone character, he may psychodramatize alone. But if the patient has certain concrete partners in mind, his concrete partners present and work out the situation with him on the stage. If the concrete person he imagines is not available he is asked to pick from among the persons present someone he imagines resembles the partner. If the patient has dreams, he is asked to psychodramatize the dream as accurately as possible. It is desirable that the patient be prepared by the psychiatrist or by another auxiliary ego for these projected situations. In psychodrama on a nonsemantic level, feeling complexes—the pantomime, the dance, music, etc., may be utilized with therapeutic effect.

An interpretation of the Moreno technique indicates: The emphasis in psychodrama, as the name suggests, is primarily therapeutic. The therapist acts as a dramatic director who, with the aid of the patient, sets up scenes involving important conflict situations in the patient's life. The patient, in company with other people called auxiliary egos, who take the role of significant figures in his life, acts out past and present life situations. This acting out of relationships is made as life-like as possible through the dramatic arts and through special training for the auxiliary egos.

The basis of the technique is the doctrine of spontaneity, which is considered a value to be developed in the personality, the development of an ability of the subject to meet new situations with adequacy. There is an inherent tendency for this to be experienced by a subject as his own state, autonomous and free from external and internal influences. Moreno's immediate goal in the beginning of treatment is not to force the patient to accept new roles.[1] He starts by providing a new imaginary world as an anchor for the patient's experiences. He supports the delusions and hallucinations of the patient and provides an "imaginary reality" in which they can be objectified. He believes that reliving the experiences on the stage does not accentuate psychotic behavior but provides bounds for it, within which the patient can begin to build new roles on the support of the old until the new roles can stand alone as "more highly organized patterns of conduct."

Moreno's technique, however, has been subjected to much criticism. Resistance to this treatment has focused on the fact that private problems are treated in public. In this technique, it is urged that private physiological problems and experiences of the most intimate kind—which have always been considered the last anchorage of individual identity—be relinquished to the group.

The individual is urged to face the truth that these experiences are not really "his" but public psychological property—the individual is told to sacrifice his splendid isolation. Further criticism of this technique includes the question by Bell[10] if, instead of spontaneity, psychodrama may not just as readily create artificiality. This has not been observed in the writer's experience. If psychodrama is used for diagnosis alone, the time involved is prohibitive for practical purposes. Actually, diagnosis turns out to be a valuable by-product. Joseph Abraham[11] contends that the procedure is complicated for therapeutic purposes by the dual relationships going on. The patient, or real person, is acting as if he were in a former situation, and the auxiliary egos are acting as if they were persons other than themselves. The patient cannot help responding to the auxiliary ego as a personality in his own right. The theoretical or practical implications of this state of affairs are manifestly rather difficult to assay. However, a therapeutic atmosphere is apparently present in this group; and the mechanisms are similar to those in other forms of group therapy. This is indicated by the reports of Moreno and his co-workers in the treatment of psychoses.

Solomon[7] states "Moreno's theory that, through 'action catharsis' and 'spontaneity' training, a learning process takes place of a sufficient degree to be of psychotherapeutic value in the treatment of psychoneurotics still requires more evidence that that now available. While it is true that some patients gain clinical improvement through abreaction in psychoanalytic treatment without conscious insight; to others, conscious insight is a very vital and important part of the treatment. The patient's response to a given psychiatric treatment and its management is always a highly individual one. Children, in playing their games, test themselves out in roles which they dare not face in reality, and, through the repetative procedure, learn to master their environment. This process may be taking place in Moreno's role-taking procedure. It is also well known that individuals normally may learn affectively that a situation which they feared—through concepts gained in childhood related to guilt feelings and anxiety—is after all innocuous and healthy. It is also true, as has been shown, that playing a part on a stage has the same unconscious meaning as playing a children's game and in addition offers a sublimation of possible unconscious, anxiety-ridden, exhibitionistic impulses, and of unconscious needs for dominance and mastery."

Solomon and Fentress[12] made an attempt to modify Moreno's approach, using analytically-oriented group psychotherapy with the techniques of dramatization of the psychodynamics to overcome what they considered deficiencies in the Moreno technique. Their technique, with war veteran patients, was used as a visual aid to insight, a catharsis-producing, abreactive mechanism, and as a basis for super-ego modification, both for the veterans whose cases were dramatized and the veterans in the audience. The Solomon and Fentress group was made up of 34 patients, and 55 dramatizations were done. Most of the group was equally divided between patients with character disorders and psychoneurotics—with three patients having schizophrenic diagnoses.

Before a patient was "dramatized," he received individual analytic psychotherapy and analytically-oriented group psychotherapy for a variable number of weeks until he was determined to be "ripe for dramatization." An autobiography was prepared by him during this period. Instructions were: Write in your own words without any attempt to organize your thoughts, a story of your life, emphasizing what you believe to be important emotional events in your life's history. If while you are writing, memories which seem to have no connection with what you have written arise, include these recollections as they occur.

Before the dramatization was begun, the autobiography was read to the audience group, consisting of other patients and the supporting cast. During the reading of the autobiography the therapist pointed out incidents, which, by their content, suggested the presence of an unconscious conflict. This was done as interpretation, but after the manner of the psychoanalyst who dismisses the patient at the end of the hour with a question to "mull over." This suspense mechanism was used to enable both the patient and those in the audience to focus attention more sharply on key material.

The patient played his own part. The supporting cast consisted of fellow patients or auxiliary aides. All acting was spontaneous. It was customary to begin with a scene containing the least conflictual pole of the presenting conflict. Scenes were permitted to flow on the basis of the patient's free associations. If greater resistance than expected was encountered, if the scenes became so repetitious as to be valueless, if the therapist felt it was opportune to develop the ambivalent aspects or other factors of a given conflict, or if he felt that it was possible to probe deeper into a given

problem, he actively interceded and redirected the course of the scene. Increasingly conflictual material was portrayed as far as the tolerance of the patient would permit. Early childhood scenes with deep etiological significance usually evolved as the dramatization developed.

Following the full dramatization, an interpretation was made by the therapist in which he pointed out such conclusions of a psychodynamic nature as he felt the patient and the audience were ready to absorb, without being traumatic to the patient.

Each patient had one to four dramatizations. The authors stated that repeated dramatization was done when the patient produced material so freely that it became obvious that it was possible to go into a much deeper level of the unconscious; when a resistance was present that could be overcome; or when there was such a clear portrayal of the deeper psychodynamics that it was of great teaching value to the patients in the audience.

The authors selected three cases for presentation in their paper because each represented different examples in the mechanism of therapy in their series. These mechanisms were: (1) abreaction of important traumatic incidents; (2) good insight by the patient into the psychodynamics of his illness; and (3) diminution in the severity of the super-ego. The authors add: "In addition to these mechanisms, the transfer situation in all of its manifestations and its proper interpretation is a vital part of the therapy in all cases."

In the first example reported in their paper, it was pointed out that the patient was extremely unapproachable when first seen. He was treated by narcosynthesis. Under sodium pentothal, he brought out strong memories of sadistic treatment by his father and showed tremendous castration anxiety. In psychotherapy after the narcosynthesis, the patient developed very little insight. After he had written his "autobiography," the patient was treated by dramatization of his psychodynamics. It is interesting to note that the patient gained—not by developing any insight, but apparently by the action which took place in the dramatic situation.

In the writer's own experiences, which will be outlined, some of the patients in the group were exposed to all these approaches except the writing of the autobiographical data. The writer employed whatever technique seemed applicable at the moment, including that defined as role-playing (reality practice). This is an action method in which the action tends to be based on the experi-

ence of a group rather than an individual. The individual may play himself, or he may take another familiar role. There is an attempt to duplicate the behavior pattern which an individual learns through the process of being a member of society. Some of the recent work on this type of approach is illustrated by the reports of Kline,[13] Bikales,[14] and Maxwell Jones.[15] According to Bikales,[14] it was found possible, in spontaneous re-enactments of incidents, to master situations which in real life had overwhelmed the patient. The friendly atmosphere, the presence of the psychiatrist and the knowledge that it was make-believe anyway, gave strength to the patient. Occasionally, great emotional relief was felt after the patient had acted out an incident. The writer's own experiences were along a similar pattern.

Procedure and Observation

The project to be reported here was begun in June 1949 with a group of schizophrenic patients assembled from the admission service of Spring Grove State Hospital. There were two aims: (1) to treat more patients in the time available, and (2) to study at first hand the use of drama in producing transient insights—with the possibility of producing total interpretations as opposed to fractional interpretation.

The group met twice a week for periods of about 75 minutes. The number in the group was kept to the maximum of 14, and, as a patient left, a new one was admitted to the group, which kept it operating continuously. The composition was mixed, with about equal numbers of male and female patients. Practically all the patients had had, or were still having, schizophrenic reactions of some type. The criteria for selection were: an indication by the patient of desire to participate, the ability to maintain a sufficient degree of self-control within this social setting, and the recommendation of the ward psychiatrist. At first, the group met in a large room, but, as activities progressed, a still larger room was provided, which had a two-step platform for a stage on which a colored spotlight could be cast. During a period of several months, sound recordings were made by means of a tape recorder. These could be played back to the patients.

A session would usually begin either with the therapist stimulating a discussion within the group or with a spontaneous discussion which would produce an incident that would be acted out. The members of the group involved in the discussion would usually act

it out. For example, a discussion might be started about ground parole, which would lead to a scene in which various patients would be re-enacting their actions while in this situation. At times, such a dramatization would practically amount to a period of free association in which most of the patients' hostility toward the institution was ventilated. Often, other areas of difficulty would be revealed, giving the therapist an opportunity to explain certain things and indicate what was being done about them.

Scenes relating to all types of social settings about the hospital were re-enacted. There might be the visit of a relative to a patient, or a discussion by two patients on the ward; rather often the doctor-patient relationship would come up. Some of the more emotionally-disturbed patients expressed a feeling of hostility toward the drama situation if they felt it was being used for other than recreational means.

Scenes evolved about problems in leaving the hospital, such as problems patients would face on getting out of a mental institution, applying for jobs, meeting old friends, or the return of a husband to a wife and vice versa. Often this gave a sharp picture of the patient's state of readiness to leave the hospital. The discussions arising in these situations would be stimulating and produce much feeling in the group.

However, after several months of work with this kind of approach, and of evaluating the activities, there was much uncertainty as to what was being contributed. Some of the puzzling aspects were that although the patients seemed to enjoy the sessions, attending regularly and even asking permission to bring other patients with whom they had become friendly, none spontaneously verbalized their feelings about it to the therapist. When patients were questioned individually as to what they felt they were getting out of it, a wide variety of answers were obtained. To some, it was an escape from the boredom of the ward; to others, it was an opportunity for socializing with members of the opposite sex. For others it was an opportunity to demonstrate histrionic abilities, self-expression and see "what other people were like." Another group always played the role of spectators, never taking an active part but always returning faithfully. These were usually the very paranoid patients. One of them verbalized his feelings as, "I came to make sure I know about everything that is going on."

It was then decided to probe a little more deeply into emotionally laden material. The courage to go on was derived from the fact that so far no untoward results had been observed, and the therapist cautiously began to employ some of the Moreno techniques. A second factor which necessitated this caution was that no one in the "therapist group" had been exposed to any supervised training in this area.

Attempts were made to develop structural situations about the patients in the group. This was an attempt to work through a patient's relationship to the significant people in his or her life. The technique here was to use auxiliary egos, trained volunteers who would play the roles against which the patient was to react. In the course of events, two of these volunteers were stimulated enough to attend Moreno's Psychodrama Institute for further training. On their return many of the maneuvers that Moreno used were introduced. These were: (1) The substitute role technique—asking a person to act out someone else. (2) Mirror technique—the auxiliary ego taking the part of the patient and mirroring his behavior to him. (3) Acting out by a patient. (4) Reversal technique—someone else plays the patient, and the patient plays someone else in relationship to the real self. (5) Double ego technique—in which the patient and the auxiliary ego objectify different sides of an inner conflict.

At the end of 18 months a total of 82 patients had been members of this group. They fell into the following four diagnostic categories:

Schizophrenic reactions	54
Affective disorders (manic-depressive, manic)	8
Psychoneuroses	3
Character disorders with psychotic episodes	17

Attendance ranged from 12 patients who were at less than 10 sessions, to 70 who had attended 10 or more. In the general patterns which emerged at the time—despite all attempts to get into deep emotional problems—activities had remained limited to a level dealing with affairs in the hospital setting and with the reenactment of episodes in interpersonal relations. It was only at very infrequent intervals that a scene of real emotional display occurred. When this happened, there was always a great deal of feeling and embarrassment in the group.

It was also noted that there was a great deal of difficulty experienced by the patients in acting out their roles. They would ver-

balize rather readily but it was extremely difficult to get them to act—in particular in any role that had an aggressive element in it. It was only the affective reaction types and the patients with character disorders who could do this with any degree of success.

Many of the drama therapy patients, while in the group, were were also receiving other forms of therapy such as electric shock treatment, insulin, group, and individual psychotherapy. There were no particular effects of the drama therapy noted in the patients' relationships to their therapy or therapist. The question had arisen as to what effect acting out in the dramatic situation might have on the individual therapy of a character disorder. No definite observations could be made.

The most striking thing noted in drama therapy was the marked effect that dramatization appeared to have on manic patients. Usually, after about 20 sessions, these individuals would show a marked amelioration in the pressure of their psychomotor symptomatologies. At about this point, they would gradually drop out of the group, saying that they felt much better and did not see any particular need for further sessions.

The following case is presented as representative of this group of affective disorders, that seemed to respond so well to dramatization technique:

The patient, Molly P., was a 32-year-old, white, Roman Catholic, attractive woman, separated from her husband. She was admitted to Spring Grove State Hospital showing pressure of speech, flight of ideas, and overactivity. She had been admitted, in March 1950, as a transfer from St. Elizabeths Hospital in Washington, D. C., where she had been taken following a suicidal attempt to slash her wrists in May 1949. Her depressive reaction finally subsided, and, in October 1949, she began visiting her family. In December 1949, her overactivity began and continued, until the time of her admission to Spring Grove. Psychological testing indicated a superior mental capacity with a manic-depressive personality structure.

She had a course of electric shock treatment in March and in May was started in drama therapy. She took part in 20 sessions over a 10-week period. She played roles in the following dramatizations: (1) Sibling rivalry; (2) development of an attack of indigestion as a result of an emotional tiff with her husband and another patient; (3) girl trouble; (4) marital difficulties; (5) doctor-patient relationships; (6) her difficulties with her husband; (7) presentation of an unpopular patient by other patients and a discussion of democratic processes; (8) parent-child conflict;

(9) hostility of one patient toward another; (10) a patient has upset several other patients by her domineering behavior—how can this be handled, etc.

During these sessions, she ran the whole gamut of emotional expression from a demure, docile, self-controlled, well-integrated personality to a yelling, swearing, emotional storm of action. Later in the course of events when Molly was questioned as to what she felt she had gotten out of her drama sessions, she stated that she "no longer felt the need" to express herself. On several occasions she had been able to ward off manic behavior by acting on the stage. In June she started to have an hour of individual psychotherapy every week and gradually started to take a much less active part in psychodrama. In September 1950, she was paroled from the hospital.

This need to act when under pressure was also expressed by other members of this group. They said that this released their feelings and that, being able to do this in a controlled situation helped the actor to stabilize himself. It was the opinion of this observer that the explanation for this was in the ego-saving role the stage presented. It was much more tolerable to the ego to function on the stage than in the ward. It was also observed that the more emotional the scene was on the stage, the more effect there was on the audience. It was also observed with this manic group of patients that there was a faculty for mimicking. It became almost a diagnostic criterion—"manics mimic."

The second case is one that falls into a group of patients who came "just to see and listen":

The patient, Sophie D., a 32-year-old, white woman, single, Greek Catholic, was admitted to Spring Grove State Hospital in June 1950 with a note stating that she was suspicious, hostile, preoccupied with religious thoughts and appeared to be hallucinating. Several weeks prior to admission, she had begun to complain of fatigue and could no longer hold her job. Following her admission, she was seen for an occasional interview, was eventually started on insulin shock, and received 50 treatments. During the period of her insulin therapy, she was in group therapy with patients receiving insulin shock. This group met once a week for 15 weeks. She was then transferred to a general group, which met once a week for a period of eight weeks. Her feeling about the group therapy was that it was hard to follow the different reactions brought up in the group. However, she stated "she did get a lot out of it." She recalled discussions about schizophrenia, and the different ways of coming out of insulin treatment, and she felt most of the discussions were oriented toward going home.

After having obtained ground parole privileges, she started to attend the drama sessions on recommendation of her ward physician. She would come

into the room, sit quietly and observe what was going on. After she had attended about 10 sessions (this was in November 1950), she was asked to give her impressions about her observations. She stated that "psychodrama made it easier for her to see what was going on rather than just listening. Some of the things that went on were sometimes confusing to her." At first she declined to take an active part but later she allowed herself to take roles, go up on the stage, and sit in on some of the discussions. She apparently is showing greater strength in testing out her socializing activities. She continues to make a good hospital adjustment, and there is reason to believe that she may eventually be able to leave.

The third case is that of a patient who has continued to run a progressively downhill course, even after exposure to a large number of sessions:

A young white man, Ted M., aged 20, single, Roman Catholic, was admitted in September 1948, with a diagnosis of schizophrenia. At the time of his presentation, there were signs indicating withdrawal. His I. Q. was 109, and his Rorschach at that time indicated a relatively normal personality with schizoid tendencies. He was found to be evasive and noncommittal, and his father considered him a religious fanatic. The patient did not want to be hospitalized because "he felt he was not wanted and that there might be dirty work involved." He had no plans for the future and displayed no urgency about leaving the hospital. At the staff meeting, at the time, opinion was divided about his being overtly psychotic.

In the hospital, he was started on individual psychotherapy for a period of several months but failed to show any response. He was given a course of electric shock treatments and then had two courses of insulin shock therapy over a period of several months. All these therapeutic efforts were unsuccessful. On the ward, his behavior continued to be erratic and unpredictable, with a superficial, supercilious attitude to whatever was going on.

Because he indicated some interest in dramatics, he was brought into the drama group. He was one of the first patients to start attending the group, and, at the time of this writing, had attended about 125 sessions. Although he is very willing to take part and seems to try to portray the roles called for, he has shown an increasing display of autistic, bizaare behavior in which he has odd mannerisms and seems to be responding to hallucinations. He verbalizes constantly but will not perform any dramatic actions of any type. His discussions wander off into mythical, metaphysical, irrelevant, contradictory talk, which he, himself, seems to be aware of. He calls himself "Puck," "the mischievous one." He seems to be aware of his frustrating devices. He has played many roles since coming to psychodrama and has taken part in all sorts of situations, but, despite everything, his course has been one of regression.

It is the impression of this observer at this time that his course would have been much more fulminating except for the dramatic activity, which has seemed to act as a brake on the development of frank hebephrenic psychosis.

The fourth case is that of Albert S., who was first admitted to the hospital in December 1941, at the age of 18, with a diagnosis of paranoid schizophrenia:

Between 1941 and 1946 there were four hospital admissions. Albert continually expressed feelings of boredom and emptiness in his life, and he felt that people avoided him. He was unstable, unable to follow any type of activity for any length of time. He had several courses of electric shock without any appreciable results. In 1946, because of his disturbing social behavior, a prefrontal lobotomy was done, and he was discharged from the hospital. His fifth admission occurred in 1948. He was found to be hyperactive, constantly moving about, scratching his face, tearing papers, disturbing other patients. He had excoriations on the hands and face. About a year and a half ago, he first started to attend psychodrama and was one of the first patients in the group. Since that time he has attended approximately 125 sessions. At first he presented all the typical features of a prefrontal case, with the concrete thinking, slow-moving pattern of associations, lack of affect, and disorganized method of presenting things. When frustrated, he lapsed into helpless silence.

He has had an opportunity to play roles and to see himself in important positions on the stage. This has apparently given some sense of satisfaction, and, despite the fact that his thinking has not changed in any particularly noticeable manner, he seems to be much quieter, socializes better, and has made a much better hospital adjustment. One of the interesting observations has been of the increasing affect he tends to display at times. In his own way, he speaks rather warmly of psychodrama; and, when he leaves the hospital for a few days on parole, he states he always looks forward to coming back. He never misses a session and is a willing, co-operative member of the group.

It has been an opportunity to observe what happens to a patient who has had a prefrontal operation and who has been exposed to this type of approach. The writer feels that there has been an amelioration of the blunting effects of the damage to the psychological processes, and that there apparently has been a certain amount of rehabilitation, in a direction that has been productive for the patient. It is an area in which further work should be done, because of the possibilities suggested by this patient.

The fifth and last case that the writer would like to present is that of Quimby S., a 55-year-old white man, with the diagnosis of involutional psychosis, paranoid type, who was admitted to the hospital in August 1949 as a transfer from the Sheppard and

Enoch Pratt Hospital. He was a former welding engineer with a history of alcoholism. It was later discovered that he was also addicted to barbiturates:

Quimby S. had had some extramural electric shock therapy prior to coming to the hospital and some in Spring Grove, which was ineffectual. His course in the hospital ran along a rather stationary level. He would complain of bizarre symptoms, such as strings in his head tying his jaws together. He was constantly demanding something to put him out of his misery, and saying he would never get out of the hospital alive, and, why didn't they just execute him and be done with it? He would clamp his jaws together and complain of grinding his teeth. At times he would threaten to ram his head against the wall, and he was constantly demanding that he be taken from the hospital.

Despite all these symptoms and complaints, it was fascinating to observe how everything all dropped away like a cloak when he came to the drama room and got on the stage. As long as the patient was on the stage, it would be extremely difficult to identify him with the individual of a few moments before. When he got off the stage it was like putting all his psychotic manifestations back on himself like a cloak. It was as if, on the stage, he was himself; off the stage it seemed as if he were acting. This phenomenon has been explained by Fenichel as due to the importance of the approving, admiring, accepting audience to the patient, who in everyday life consistently exhibited in a negative way and yet on the stage uniformly gave unusually creditable performances. He is one of those individuals who are hypersensitive to rejection but whose strong oral, demanding attitudes cause them to provoke further rejections.

As to the role of fantasy in the dramatic situation, the writer one day had the opportunity to observe this at rather close range. An attempt was being made to get the group warmed up to discussing something which would be used as a theme around which to structure a drama session. On this particular occasion the director left things in the hands of the group. A plot was suggested by one of the schizophrenic patients and immediately picked up by the others. This was the suggestion—that a murder be portrayed on the stage, and that the audience then would discuss what had taken place. What was in the mind of the patient—a paranoid schizophrenic—who suggested the idea was to point out the unreliability of witnesses. In a rather loose fashion, a scene evolved in which three assassins (patients) plotted the murder of another patient (Ted), a hebephrenic, who was disliked by the others because of his attempts to dominate the dramatic sessions. His efforts would frustrate the others because of his irrelevant, incoher-

ent attitude, and preoccupation with himself. In one of the scenes, "the Ghost," now played by Ted, returned to haunt those who had been against him. In the final scene, the assassins were tried and found guilty in a mock trial. During the discussion, it was brought out almost unanimously by the patients that what they preferred during the drama sessions was something realistic, something dealing with their own problems, which could be applied to the group itself. They were not interested in fantasy productions.

It is also observed that dramatization was a useful projective technique, in helping to achieve accurate information of the effect of psychotherapy. Also, it was often found that a patient would have several different diagnoses by different observers prior to coming to the dramatic group. After a period in this group, however, when an opportunity was had to observe the way he related himself to other people and his handling of the interpersonal situations and the activities that went on on the stage, it was not too difficult to separate the psychoneurotic from the character disorder and the psychopath. It was a very effective method in determining in what patients there were still so strong anti-social tendencies that they should not be released from the hospital. In the other diagnostic classifications, drama therapy helped to differentiate the affective disorders from the schizophrenic reactions. Even those patients who merely came as listeners, and who did not take active part in the group, indicated much about themselves by the way they related in this particular situation.

As the sessions progressed, it became apparent that certain types of patients had to be kept out, to get the most out of the group. Mental defectives contributed nothing and, when they became involved in a situation, handled it inappropriately—much to the discomfort of the other patients. It was also felt that patients with character disorders, or the psychopathic personalities, had little to gain from this type of activity. Apparently the only important role the dramatization could play, in reference to these patients, was in giving some clue as to how much insight they had gained into understanding of their interpersonal relations and as to what changes had taken place, if any.

At one time it was felt that psychodrama or dramatization activities would block the treatment of the character disorders by individual psychotherapy. It was found that, as a result of the catharsis which had taken place in the dramatic setting, patients,

on their return to individual therapy, were unproductive. Since several of the therapists working with these patients had complained about this, three who fell into this classification were dropped from the psychodrama situation. However, it was interesting to note that several months later, in rechecking on these patients, it was found that the therapists working with them had also dropped them. For all practical purposes, the patient was in the original *status quo*. It was the opinion of this observer that psychodrama actually does not interfere with anything that might be going on in the individual's psychotherapeutic situation, regardless of the type of disorder. If anything, it tends to increase the therapeutic potential.

Other facets of interest in the situation were that there is never any applause in the psychodramatic setting. What this means is not quite clear, but apparently it tends to emphasize the therapeutic nature of the group. Sessions rarely went into intimate details of a patient's life. Reluctance to do this was based on many factors which as yet have not been clearly formulated.

Discussion

If we accept drama as a medium of therapy, it is of interest to indicate what is meant by psychotherapy. The answer which appeals to this writer is the one broadly outlined by Kubie.[16] He holds that psychotherapy, in a loose sense, embraces any effort to influence human thought or feeling or conduct, by precept or by example, by wit or humor, by exhortation or appeals to reason, by distraction or diversion, by rewards or punishments, by charity or social service, by education or the contagion of another's spirit. The broadest possible use of the term would also include the temporary lift of spirit through music, art, and literature. Such methods as these depend upon an artful blend of imagination, feeling, intuition, firmness and common sense.[16]

It is Kubie's thesis that, as a science, psychotherapy begins only where these leave off. The critical difference must not be sought, either in the act or its setting, but in the determining mechanisms of the act. "Behavior is normal or abnormal," he says, "because of the nature of the inner forces which produce it. What then are the characteristics of the inner determining forces which make any moment of thought, feeling or action normal and what are the characteristics which make it neurotic. The answer to this requires one further distinction—a distinction between the forces

which are within the range of our conscious perceptions and those which are so deeply buried as to be inaccessible to any introspective knowledge of ourselves."

Drama therapy, in the light of this definition of psychotherapy, falls out of the realm of science. The illness which this method attempts to treat is characterized by an endless repetitiveness. "It is . . . this repetitiveness," says Kubie, "which constitutes the essential challenge to psychotherapy and its most difficult problem. However, the approach to this ultimate stronghold is always preceded by less complicated preparatory maneuvers."

One may have some conception of how drama therapy affects the simpler psychotherapeutic expedients which can be grouped, according to Kubie, "under three main headings: (a) Practical support—consisting primarily of advice, guidance, and assistance in the management of life situations and environmental difficulties through social service aids, etc. (b) Emotional support—consisting essentially of sympathy, exhortation, admonition, encouragement, art, recreation, companionship, etc. [and opportunity to act out in an understanding environment]. (c) Reorienting education—consisting primarily of efforts to alter the patient's habitual attitudes of guilt, fear, hate, and depression, by educating him to tolerate his own conscious and unconscious needs and cravings, his instinctual hungers, his familial jealousies and hates, etc."

One can understand the difficulties with this type of technique in a reorienting education through the development of insight, where an extensive knowledge of unconscious psychological forces is necessary. To quote Kubie again, "psychotherapy cannot always achieve, or even aim at, the eradication of causes. As in any other medical discipline, it must sometimes content itself with palliative measures. Palliative psychotherapy consists primarily of an effort to teach patients how to live with some measure of comfort within the confines of their uncured neuroses." How much we can accomplish by the procedure of drama therapy is still a subject for study.

Conclusion

1. Group therapy with schizophrenic patients, through the mechanism of dramatization, is a potent force in stimulating group dynamics.

2. It has its greatest effect on patients with predominantly affective reactions.

3. It has a tendency to increase the therapeutic potential of the patient who may have rejected individual psychotherapy or who cannot obtain individual psychotherapy because of the basic economics of the state hospital.

4. In the study reported here, no patients were cured by this method alone, but it was a very effective palliative measure in helping the patient stabilize himself as a social being.

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AN OUTLINE OF THE NATURE OF SOME SEXUAL REACTIONS TO THE INDUCTION OF HYPNOSIS*

BY MILTON V. KLINE, Ph.D.

Some of the sexual aspects of hypnosis and of hypnotic reactions have been investigated from various points of view. It is not the purpose of this paper to discuss such studies, since they are to be found in already-published material. However, it has been noted by some investigators that psychosomatic reactions to the induction of hypnosis and other aspects of sexuality during hypnosis have a relationship to the psychodynamic process which produces the response.

Schneck,[1] in reporting on psychosomatic reactions to the induction of hypnosis, found that "the reactions constitute somatic expression of anxiety associated with hypnotic experience, or defenses against it. The hypnotic experience apparently constituted a vague, ill-defined and intensely threatening, noxious agent which was potentially capable of overwhelming these patients, permitting thereby the uprooting of defenses erected against the exposure of unconscious conflict."

From this point of view, hypnosis can be considered a threat in the form of an interpersonal relationship, and the reactions to it would be similar to resistances to nonhypnotic transference relationships which might either strip the patient of his defenses or arouse sexual conflicts because of increased sexual impulsivity. In the latter connection, Schneck[2] comments on patients in hypnosis who equate homosexuality with hypnosis. He writes: "The meaning of hypnosis which related to the equating of hypnosis and homosexuality had been unconscious prior to therapy. This material is consistent with previously expressed views regarding the advisability of investigating certain aspects of hypnosis from the viewpoint of its relationship to a reactivation of the Oedipal situation, elements of castration anxiety, and masochistic components."

Both in psychosomatic reactions to the induction of hypnosis and in the equating of hypnosis with homosexuality, the psychodynamic mechanism for the response existed prior to contact with

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the hypnotist. The question arises as to the stimulus activating this pattern of response. It is evident that the reaction pattern existed on an unconscious level and, with sufficient stimulation, became organized into effector activity. The nature of such complex psychological activity is not obviously clear, nor does it appear to be simple. Several hypotheses can be stated:

1. The stimulus could be hypnosis *per se,* and the changes in neuropsychological organization which have been reported to accompany the induction of hypnosis. Clinical and psychometric alterations in ego-function have been noted in response to hypnosis *per se.*[3]

2. The stimulus could be the threat of, or the activation of, a transference relationship which is quickly crystallized and synthesized in the patient's receptive perceptuality, because of alterations in receptor function which can accompany the induction of hypnosis.

3. The stimulus could be a *conditioned* response, either to the transference or to elements of the hypnotic procedure related to it.

4. The stimulus could be an *associated* response, either to the transference situation or to elements of the hypnotic procedure related to it.

5. The stimulus could be a configuration of all the aforementioned components, stemming directly from association to the words of the hypnotist. Such a Gestalt-like response to hypnosis might involve transference threat, increased transference-impulse drives, neuropsychological changes in ego function resulting from hypnosis *per se,* conditioned response patterns and associated imagery activity. Evidence to support this idea will now be presented.

Case Material

Case 1. A 24-year-old, married woman patient was being seen for psychotherapy because of poor marital and vocational adjustment. Following diagnostic psychological testing and three clinical interviews, hypnosis was suggested as a technique within the therapeutic setting. The patient voiced no objection, and an induction was accomplished in a brief time. The first hypnotic session produced a medium trance state, characterized by eye closure, arm and leg catalepsy, and inability to open the eyes. No amnesia was present post-hypnotically, and none was suggested. The pa-

tient expressed satisfaction with the procedure, and arrangements were made to continue with hypnosis at the next session.

Whereas the first hypnotic session had produced no resistance of note, the second session was characterized by intense resistance. The patient was able to enter a light trance state; but, when suggestions for deepening it were given, she stiffened perceptibly and began to bite her lips. She did not come out of the hypnosis but appeared markedly uncomfortable. Her hands, which had been at her sides until then; were placed over her vagina and held in a rigid position. She bent over into a doubled-up position and turned from a position in which she had been lying on her back to one in which she was on her side, facing a wall away from the therapist. When further suggestions for increased trance-depth were given, her eyes opened and she sat up. She was clearly out of the hypnotic state and seemed rather confused. She said that the hypnotic experience was an unpleasant one this time, and she thought that perhaps she would prefer not to use it. Arrangements were made to have a regular interview at the next therapeutic session.

The next session found the patient rather apologetic for her behavior during the hypnotic attempt, though quite resolute against further work with hypnosis. When she was asked why she had become uncomfortable on the previous occasion, no explanation of any significance was obtained.

Psychotherapeutic contacts continued on a nondirective basis for six weeks, during which a positive transference developed. At this time, the patient spontaneously brought up her reactions to the second induction of hypnosis and remarked, "You know, there was something about that second session with hypnosis that I have wanted to tell you but I haven't been able to say it until now. When you told me I was going deeper and deeper into a hypnotic sleep, I had a picture in my mind of myself and ——— [a girlfriend with whom the patient had maintained a homosexual relationship] lying on a bed. I was fondling her breasts and she was going deeper and deeper into my vagina. I was very disturbed by this picture." When asked what she thought had stimulated the picture in her mind, she replied, "The word *deep*—it immediately reminded me of intercourse."

Case 2. A 22-year-old married woman was referred for psychotherapy because of sexual frigidity. She verbalized no other

personality difficulty, though diagnostic psychological testing revealed a markedly obsessive and compulsive individual with hysterical tendencies. At first she was seen on a nondirective basis. As the transference became more positive, a more directive technique was employed. Hypnosis was suggested as an explorative procedure, and the patient readily agreed to its use. An eye-fixation technique was used, and at the point where eye closure was suggested it became apparent that the patient was resisting the approaching hypnosis. She clenched her hands together and began to "wring" them in a "washing" motion. Her facial expression changed from one of passivity and ease to one of rigid discomfort which included the gritting of her teeth. Body posture became stiff, rather than relaxed, as it had been a moment before, and heavy breathing was noted.

Eye closure was obtained, despite the resistance, and although the resistance persisted in a manner similar to that just described, a light state was used over a period of several weeks for hypnodiagnostic work in connection with psychotherapy. No attempt was made to investigate the nature of the resistance until about eight weeks after the first spontaneous reaction to the induction procedure.

By this time, the patient was capable of entering a light trance state more easily and had been trained in automatic writing. At this point in therapy the patient was asked to write out her feelings about the first hypnotic session. She wrote, among other things: "When you said my eyelids were going down, down, down—I saw myself in bed and I thought of having intercourse. The penis was going down, down, and down but it was no good—I couldn't do anything. I had failed again. I thought I was going to fail in the hypnosis too. This made me feel very angry and upset."

When asked what it was specifically that brought about this experience, the patient remarked, "The word *down* immediately reminded me of movement in intercourse—I don't know why but it did." When presented with this information in the waking state, the patient evidenced surprise at it. She indicated that she had not been aware of that particular experience in connection with the hypnotic procedure.

Discussion

In both of the reported cases of resistance to the induction of hypnosis, the subjects reacted with spontaneous motor reactions

and imagery formations. In both cases, the initial stimulus for the form of the resistance reaction was a word used by the hypnotist during the induction procedure. Bull and Gidro-Frank have indicated that the presentation of a stimulus word such as "disgust" or "fear" can, when the subject is told to do so, bring on psychomotor changes and psychological activity essentially the same as that observed in natural expressions of such emotions.[4, 5] In the cases presented here, words employed by the hypnotist in the induction procedure were associated to by the patients. The associations produced visualizations, the nature of which embodied elements of major conflict for the subjects. Other work with hypnotic scene-visualizations and the word association test has indicated that subjects may react with scenes of two types. One tends to embody components of the individual's parental identificational development and is essentially an image-agglutination or condensation. The other type represents a secondary visual association, based upon situational or ego-experiential memories.[6, 7] The condensed visualization would seem to have chief meaning in relation to transference movement and patterning on a patient's part. Secondary visualizations might tend to represent more of the ego defenses and of the adaptive mechanisms of a subject.

Either type of image-formation can produce marked resistance on the part of the patient in a clinical psychological setting. From the data presented here it would seem that the word associated to, in the hypnotic induction procedure, assumed its perceptive importance and imagery because of the nature of the hypnotic setting. Following the word association, it would appear that the spontaneous psychomotor reactions occurred as a result of conditioned responses to the associated "concept" involved in the image activity. From this viewpoint, it would appear that the more subtle and complex elements in the patient's resistance are based upon the psychodynamic content and type of visualization. Where transference impulses are involved, a more active sexual component is incorporated in the subject's reactivity. Where a secondary visualization is involved, a more defensive or somatic psychological reaction may be evidenced. Though many functions are seen in this outline of the nature of some resistances to the induction of hypnosis, the actual organization of resistance-behavior may appear to be spontaneous activity. The fusing of associated,

with conditioned, responses is in keeping with the alterations in ego functions that were previously reported to accompany hypnosis *per se* in a clinical psychological setting.[3]

Resistance to hypnosis thus embodies a gestalt of highly complex patterns of neuropsychological functioning, including word-associations, conditioned responses, conceptual organization, and imagery activity—and, from this stimulating-organizing activity, impulse-expressions of transference or of more secondary defensive mechanisms. The result would, to a large degree, depend upon the extent of unconscious activity and the psychological status of the particular subject.

A process so fused and so related to the basic elements in personality structure can in itself be very revealing with respect to psychodiagnosis. As already suggested by Guze,[5] it would seem that the reactions to the induction of hypnosis in itself can be utilized as a projective technique in clinical psychology. With appropriate exploration and investigation, the induction of hypnosis can be very revealing of psychodynamic material pertinent to psychological diagnosis and clinically useful in the therapeutic process.

Although the hypnotic state *per se* would appear to play a facilitating role in the organization of resistance patterns, it would seem, from the data presented here, that, in some cases, the specific words used in the hypnotic induction procedure serve as the stimuli for the production of resistance behavior. This would seem to be particularly true where the resistance has sexual portent. Thus, sexual involvement may be somewhat controlled by the hypnotist through careful attention to the selection of words in hypnotic instructions. In this manner, resistance may be diminished, or may be increased for therapeutic purposes at an appropriate time. Experimental workers should take very careful note of the wording of the instructions they give, if they wish to avoid free and conditioned responses which—through unconscious psychological activity—may alter the variables with which they are working. It is likely that the careful selection of his instruction terminology can increase the degree of control exercised by the hypnotist in any setting, thus facilitating the interpretation of data which may be obtained in all hypnosis work, whether clinical or experimental.

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A NOTE ON AESTHETIC CRITERIA IN PERSONALITY EVALUATION

BY W. T. LHAMON, M. D.

In the clinical practice of psychiatry there is a recurrent need to evaluate personality status. One may want to decide on the probable future of a patient, or to determine the wisdom of starting treatment, or to decide on a change in the method of treatment or the termination of treatment, or to decide on the efficacy of present treatment as against previous treatment. In any such case, the immediate and current value or worthwhileness of a given personality status must be established with as much accuracy as possible.

Ordinarily, this means a study of a "cross-section" of the personality; it means a picture of the current dynamics with consideration of the most likely future developments, and with a value judgment of the present situation. The constant change, variation and growth of a person have to be stopped or "frozen" long enough for an accounting to be made of the worth, value, and status at the current instant. In making this current evaluation, the clinician compares the personality at a given instance of time with the personality at some previous moment of time, or with another personality, or with an idealized personality. In any case, the actual operation consists of making comparisons with standards of reference, according to certain criteria or combinations of criteria. Psychiatry in practice presents a bewildering constellation of factors requiring consideration at the moment of judgment: Age, culture, personality, situation, duration and type of illness all are involved.

As has just been indicated, the information bearing on the functioning and value of a patient's personality has to be collected periodically, and pulled together for decision on such matters as to what path of treatment to follow in the future, etc. This has been done in the past by means of the "mental status examination."[1] This has been most useful in the recording of factual data as a basis for the continuing care and future evaluation of hospitalized psychiatric patients. The emphasis in such an examination is on the full observation of the patient at periodic intervals. Patients in which this procedure is applied are usually grossly ill; it has been used much less often in assessing office or clinic

patients than in hospitalized patients. It is possible that the segments and divisions of the standard mental status examination do not easily fit into the work of office psychotherapy, by reason of the time required, and, perhaps also, because the subtle difficulties of the office patient are not easily delineated in terms of the mental examination. In any case, the major purpose of the standard mental examination, that of recording factual information bearing on the medico-psychological status of the patient, is anterior to the evaluation process required.

The taking and recording of a mental examination do not satisfy the needs for assessment with which one is so constantly faced. These needs are, to a certain extent, partially met by the "personality study" commonly used in the observation and working up of psychiatric problems. The objections to this procedure are, first, that the time base is too long. Ordinarily in a personality study one tries to depict the personality, and usually to make some evaluation of it, as a "statistical" average, up to the time of the present illness. While this is of undoubted importance in the maximum understanding of, and rational therapeutic working with patients, the emphasis in the personality study is also anterior to the evaluation process required in periodic reformulations. Practically, the crux of the matter is the need for periodic reformulations, using current information however gathered and recorded.

Much of the information in clinical psychiatry is not of the type available to the physical sciences, in which corroboration can be attained through repetition—to nearly any desired degree of accuracy. In medical practice, and particularly in psychiatric practice, much of the evidence corresponds to circumstantial evidence, and depends on the convergence of many different kinds of fugitive material, most of which indicate the ultimate conclusion. Usually the same circumstances are not repeatable; this means that we cannot often employ effectively-controlled observations as a basis for reaching conclusions. The available data are at present, unfortunately, too transient for repetition; one must use instead many items pointing in the direction of final evaluation. The comparisons and judgments involved in the clinical evaluations of patients and their personalities ordinarily are thought of as "clinical judgment," presumably to distinguish this from some other sort of judgment, such as that based on controlled experiment. These judgments comprise the art of medicine. It is the

writer's point that they might better be treated as aesthetic judgments. The systematic approach of the aesthetician may provide a useful tool in making clinical and largely aesthetic judgments in psychiatric practice with greater efficiency, and especially with greater probability that the full range of facts will be considered. Many excellent clinicians operate with concepts, frames of reference, and criteria of which they are not aware. Awareness of the bases of clinical judgments according to several valid systems of reference should lead to greater ability to communicate the reasons for these judgments to others. And while it is true that the facts will not lead to readings that can be noted on a dial-and-pointer instrument, they can be handled with considerable reliability and satisfaction with the methods of aesthetic criticism. Certain difficulties of conception arise in treating the personality in the same fashion in which one might treat objects in the aesthetic field such as pictures, literary works, percepts of nature, crafts, or musical compositions. Nevertheless, a case can be made for studying the personality for purposes of evaluation as one might study a work of art. The fluidity and changeability of the personality are no greater than those of many natural perceptions, such as landscapes or flowers, which have only a fleeting stability in time. As with any matter in the common-sense aesthetic field, so does the personality have a greater or less value, depending on the criteria applied.

Collections of evidence may be studied according to some system which emphasizes certain connections among the evidence. According to Pepper[2] there are four relatively valid philosophical systems leading to conclusions based on empirical facts. (See the accompanying table.) Formism may be considered the first of

Outline of Criteria for Personality Status Evaluation

Type of approach	Criteria
1. Formistic	Degree of conformity to the norms of human nature and to the norm for the cultural group.
2. Hedonistic	Amount of pleasure obtained and number of ways pleasure is obtained.
3. Contextualistic	Number of voluntary vivid affective responses to situations. Intensity of affect. Optimal presence of conflict.
4. Organistic	Consistency and harmonious integration of personality features, with maximum freedom from unconscious distortion of motivation, perception and behavior.

these relatively adequate philosophies. This view holds that the greatest value inheres in whatever is closest to the "normal," and that whatever would be satisfying to a normal, healthy man is of value. Thus disease and distortion, or eccentricity, would be of less value than health and normality. Normality can be viewed in terms of the species, or in the case of patients, in terms of general universal human normality, rather than in terms of accidental or detailed aspects of personality; this corresponds in a way to the degree to which the patient approaches the common-sense ideal of "human nature." In addition we can evaluate the approach of the person to the norm of his particular cultural group. While formistic criteria of value may seem to be self-evident, it should be noted that, on a practical level, in psychiatry, deviation from "normality" is used often in determining the severity of illness, and, furthermore, that normality in a given culture has survival value, a value which has certainly entered into formation of the norm in the first place. Consideration of greater or less conformity to a norm is sometimes lost sight of in our clinical evaluations, or is undertaken intuitively. Yet in one sense, this hypothesis is the basis for the first question usually asked in evaluating progress—whether the symptoms of the presenting complaint have disappeared or become less troublesome.

The second relatively valid philosophy to be considered is that of hedonism, called by Pepper[2] the mechanistic point of view. According to this view, as applied to the aesthetic field, the goodness or worthwhileness of an object inheres in the absolute amount of pleasure which can be obtained from the object. Application of the hypothesis to the evaluation of personality leads to conclusions on the basis of how much pleasure is obtained by the person under consideration. Two aspects of hedonism are involved. First there is the total amount of pleasure the person obtains and second, one wishes to know how varied and numerous are the ways in which he can obtain pleasure. One wishes to know the extent to which maximum attainment of these pleasures has been approached by the person. It will be seen that this has a relationship to the "assets" of the personality, to the number of interests, and to the ease of relaxation and enjoyment. This procedure involves a process of identification with the person under consideration; instead of evaluating the pleasure given by the personality to the observer, as one would judge a painting for instance, one

evaluates the pleasure available to the person, or his potentialities for obtaining pleasure in the interval under consideration.

In this connection it seems best to avoid the usual objection to hedonism that pleasure of the immediate type need not lead to happiness in the long run. It is understood that immediate pleasure may be put aside in favor of later pleasure. Objections that tragic values cannot be understood on a hedonistic basis also seem best avoided at this juncture; tragic values are best understood under another frame of reference, that of pragmatism, which will be considered later. An ability to obtain simple, as well as complex, pleasures, the enjoyment of instinctual satisfactions, the number of avenues to such pleasures and the intensity of immediate enjoyment of pleasures would constitute criteria on which an evaluation can be based of the status of the personality according to this approach.

Such an evaluation can be relatively quantitative in terms of some other time in the person's life, or according to cultural and social standards of the group to which the person belongs. Underlying causes of the presence or absence of the sense of pleasure are not pertinent here; what is needed is an estimate of the number of ways the person obtains immediate pleasure, and the degree of such pleasure. Existence of evidence that pleasurable activity occurs unconsciously, as in dreams or in fantasy and in associations, is pertinent as giving indications that pleasure exists within the personality.

A third relatively valid philosophy is that of pragmatism. This hypothesis results in what Pepper calls contextualistic criteria when applied to aesthetics. In this view, great value is to be found in the experiencing of things or events. As applied to personality, one wishes to know if there is optimal intensity and depth of feeling. These considerations revolve around the common psychiatric topic of affect, and the general matter of emotional status. One is not primarily concerned here with whether the feelings experienced are those of pleasure or pain, as in the hedonistic view, but only that there be optimal feeling experienced, of whatever type. The concept of aesthetic distance may be applied; it is desirable that the intensity of emotion should not be so great as to result in disability or withdrawal. One wishes to become aware of, and to eliminate, whatever barriers there might be to full and vivid feeling in the patient's everyday life. It is within the frame-

work of this philosophy that we can understand the worthwhileness of sadness and tragedy, remembering that the intensity of experience should not be so great as to lead to withdrawal and numbness.

Sensitivity of feeling, the capacity for emotional response to others and to the environment generally, is a component criterion of this philosophy as applied to the evaluation of personality. It has been suggested by Pepper that the material falling within this approach be restricted to voluntary vivid intuitions of quality, in order to exclude involuntary painful experiences. In any case, the emphasis is upon the richness and intensity of experience. As an organized set of criteria for evaluating personality, it will be seen that this hypothesis is concerned with the situation rather than entirely with the environment or with the person alone; thus comes the term "contextualistic." Vividness and richness of experiencing within a situation is, then, to be looked for. The hypothesis directs attention to the situation, as well as to the person, and provides a needed check upon the tendency to consider a person within a vacuum or without reference to the immediate environment in which he lives. Another aspect of the pragmatic or contextualistic approach to personality evaluation is tolerance for conflict. Conflict is of value in view of the richness and intensity of experience which may be reached through it, provided the conflict does not exceed an amplitude beyond which value decreases, aesthetic distance is not sufficiently maintained, and disability ensues. In other words, in this view it is desirable for a person to be emotionally involved in conflict of an intensity below a critical level. The presence of rigid adherence to routine, excess practical activity, and excess analysis, all of which reduce the enthusiasm and affective response in situations, needs to be considered.

Finally there is the organistic approach, the philosophy of objective idealism, in which is stressed coherence and internal relatedness. When applied to aesthetics, criteria of the integration and coherence of feeling and behavior result. In terms of personality evaluation, the criteria of this world view would stress the consistency and integration of behavior, including perception and feeling. The flexible, harmonious, working together of the different parts of the personality is desired, without special reference to normality, pleasure obtained, or intensity and depth of feeling. This hypothesis, with its resulting criteria, is inclusive of optimal freedom from the unconscious motivations and motivation distor-

tions described by Kubie,[3] who stresses the point that when motivations are within consciousness, rather than inaccessible in the unconscious, adaptability to reality is furthered. One would consider most desirable a personality with a minimum of unconscious distortion of feeling, behavior, perception, and motivation. There should be an optimum—and as large as possible—amount of material within awareness, and subject to the integrating processes available for material within consciousness. In psychiatric practice the implications of this world view are commonly prominent in personality evaluation; the criteria of internal relatedness and coherence of things, when expressed in terms applicable to personality, touch upon the modern interest in motivations, upon the unconscious factors in behavior and perception, and upon the balance and imbalance of psychodynamic forces. From these considerations can emerge an evaluation of the efficiency level at which the personality is operating, as well as a comparison with other moments in the person's life. A judgment of actual performance and value as against possible performance and value can be made.

In summary, when four major criteria—normality; pleasure obtained; richness of experience and response to situations; and the optimal integration and harmonious working together of personality factors—are applied regularly in the process of personality evaluation, there is good probability that the full range of pertinent data will be considered in the light of what have been found the most useful and relatively valid methods of handling the type of information ordinarily found in everyday clinical personality evaluation. A combination of these four relatively valid criteria may serve to prevent too great diffusion, or excessively narrow concentration on one or another aspect of personality.

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and imagery formations. In both cases, the initial stimulus for the form of the resistance reaction was a word used by the hypnotist during the induction procedure. Bull and Gidro-Frank have indicated that the presentation of a stimulus word such as "disgust" or "fear" can, when the subject is told to do so, bring on psychomotor changes and psychological activity essentially the same as that observed in natural expressions of such emotions.[4, 5] In the cases presented here, words employed by the hypnotist in the induction procedure were associated to by the patients. The associations produced visualizations, the nature of which embodied elements of major conflict for the subjects. Other work with hypnotic scene-visualizations and the word association test has indicated that subjects may react with scenes of two types. One tends to embody components of the individual's parental identificational development and is essentially an image-agglutination or condensation. The other type represents a secondary visual association, based upon situational or ego-experiential memories.[6, 7] The condensed visualization would seem to have chief meaning in relation to transference movement and patterning on a patient's part. Secondary visualizations might tend to represent more of the ego defenses and of the adaptive mechanisms of a subject.

Either type of image-formation can produce marked resistance on the part of the patient in a clinical psychological setting. From the data presented here it would seem that the word associated to, in the hypnotic induction procedure, assumed its perceptive importance and imagery because of the nature of the hypnotic setting. Following the word association, it would appear that the spontaneous psychomotor reactions occurred as a result of conditioned responses to the associated "concept" involved in the image activity. From this viewpoint, it would appear that the more subtle and complex elements in the patient's resistance are based upon the psychodynamic content and type of visualization. Where transference impulses are involved, a more active sexual component is incorporated in the subject's reactivity. Where a secondary visualization is involved, a more defensive or somatic psychological reaction may be evidenced. Though many functions are seen in this outline of the nature of some resistances to the induction of hypnosis, the actual organization of resistance-behavior may appear to be spontaneous activity. The fusing of associated,

with conditioned, responses is in keeping with the alterations in ego functions that were previously reported to accompany hypnosis *per se* in a clinical psychological setting.[3]

Resistance to hypnosis thus embodies a gestalt of highly complex patterns of neuropsychological functioning, including word-associations, conditioned responses, conceptual organization, and imagery activity—and, from this stimulating-organizing activity, impulse-expressions of transference or of more secondary defensive mechanisms. The result would, to a large degree, depend upon the extent of unconscious activity and the psychological status of the particular subject.

A process so fused and so related to the basic elements in personality structure can in itself be very revealing with respect to psychodiagnosis. As already suggested by Guze,[5] it would seem that the reactions to the induction of hypnosis in itself can be utilized as a projective technique in clinical psychology. With appropriate exploration and investigation, the induction of hypnosis can be very revealing of psychodynamic material pertinent to psychological diagnosis and clinically useful in the therapeutic process.

Although the hypnotic state *per se* would appear to play a facilitating role in the organization of resistance patterns, it would seem, from the data presented here, that, in some cases, the specific words used in the hypnotic induction procedure serve as the stimuli for the production of resistance behavior. This would seem to be particularly true where the resistance has sexual portent. Thus, sexual involvement may be somewhat controlled by the hypnotist through careful attention to the selection of words in hypnotic instructions. In this manner, resistance may be diminished, or may be increased for therapeutic purposes at an appropriate time. Experimental workers should take very careful note of the wording of the instructions they give, if they wish to avoid free and conditioned responses which—through unconscious psychological activity—may alter the variables with which they are working. It is likely that the careful selection of his instruction terminology can increase the degree of control exercised by the hypnotist in any setting, thus facilitating the interpretation of data which may be obtained in all hypnosis work, whether clinical or experimental.

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A NOTE ON AESTHETIC CRITERIA IN PERSONALITY EVALUATION

BY W. T. LHAMON, M. D.

In the clinical practice of psychiatry there is a recurrent need to evaluate personality status. One may want to decide on the probable future of a patient, or to determine the wisdom of starting treatment, or to decide on a change in the method of treatment or the termination of treatment, or to decide on the efficacy of present treatment as against previous treatment. In any such case, the immediate and current value or worthwhileness of a given personality status must be established with as much accuracy as possible.

Ordinarily, this means a study of a "cross-section" of the personality; it means a picture of the current dynamics with consideration of the most likely future developments, and with a value judgment of the present situation. The constant change, variation and growth of a person have to be stopped or "frozen" long enough for an accounting to be made of the worth, value, and status at the current instant. In making this current evaluation, the clinician compares the personality at a given instance of time with the personality at some previous moment of time, or with another personality, or with an idealized personality. In any case, the actual operation consists of making comparisons with standards of reference, according to certain criteria or combinations of criteria. Psychiatry in practice presents a bewildering constellation of factors requiring consideration at the moment of judgment: Age, culture, personality, situation, duration and type of illness all are involved.

As has just been indicated, the information bearing on the functioning and value of a patient's personality has to be collected periodically, and pulled together for decision on such matters as to what path of treatment to follow in the future, etc. This has been done in the past by means of the "mental status examination."[1] This has been most useful in the recording of factual data as a basis for the continuing care and future evaluation of hospitalized psychiatric patients. The emphasis in such an examination is on the full observation of the patient at periodic intervals. Patients in which this procedure is applied are usually grossly ill; it has been used much less often in assessing office or clinic

patients than in hospitalized patients. It is possible that the segments and divisions of the standard mental status examination do not easily fit into the work of office psychotherapy, by reason of the time required, and, perhaps also, because the subtle difficulties of the office patient are not easily delineated in terms of the mental examination. In any case, the major purpose of the standard mental examination, that of recording factual information bearing on the medico-psychological status of the patient, is anterior to the evaluation process required.

The taking and recording of a mental examination do not satisfy the needs for assessment with which one is so constantly faced. These needs are, to a certain extent, partially met by the "personality study" commonly used in the observation and working up of psychiatric problems. The objections to this procedure are, first, that the time base is too long. Ordinarily in a personality study one tries to depict the personality, and usually to make some evaluation of it, as a "statistical" average, up to the time of the present illness. While this is of undoubted importance in the maximum understanding of, and rational therapeutic working with patients, the emphasis in the personality study is also anterior to the evaluation process required in periodic reformulations. Practically, the crux of the matter is the need for periodic reformulations, using current information however gathered and recorded.

Much of the information in clinical psychiatry is not of the type available to the physical sciences, in which corroboration can be attained through repetition—to nearly any desired degree of accuracy. In medical practice, and particularly in psychiatric practice, much of the evidence corresponds to circumstantial evidence, and depends on the convergence of many different kinds of fugitive material, most of which indicate the ultimate conclusion. Usually the same circumstances are not repeatable; this means that we cannot often employ effectively-controlled observations as a basis for reaching conclusions. The available data are at present, unfortunately, too transient for repetition; one must use instead many items pointing in the direction of final evaluation. The comparisons and judgments involved in the clinical evaluations of patients and their personalities ordinarily are thought of as "clinical judgment," presumably to distinguish this from some other sort of judgment, such as that based on controlled experiment. These judgments comprise the art of medicine. It is the

writer's point that they might better be treated as aesthetic judgments. The systematic approach of the aesthetician may provide a useful tool in making clinical and largely aesthetic judgments in psychiatric practice with greater efficiency, and especially with greater probability that the full range of facts will be considered. Many excellent clinicians operate with concepts, frames of reference, and criteria of which they are not aware. Awareness of the bases of clinical judgments according to several valid systems of reference should lead to greater ability to communicate the reasons for these judgments to others. And while it is true that the facts will not lead to readings that can be noted on a dial-and-pointer instrument, they can be handled with considerable reliability and satisfaction with the methods of aesthetic criticism. Certain difficulties of conception arise in treating the personality in the same fashion in which one might treat objects in the aesthetic field such as pictures, literary works, percepts of nature, crafts, or musical compositions. Nevertheless, a case can be made for studying the personality for purposes of evaluation as one might study a work of art. The fluidity and changeability of the personality are no greater than those of many natural perceptions, such as landscapes or flowers, which have only a fleeting stability in time. As with any matter in the common-sense aesthetic field, so does the personality have a greater or less value, depending on the criteria applied.

Collections of evidence may be studied according to some system which emphasizes certain connections among the evidence. According to Pepper[2] there are four relatively valid philosophical systems leading to conclusions based on empirical facts. (See the accompanying table.) Formism may be considered the first of

Outline of Criteria for Personality Status Evaluation

Type of approach	Criteria
1. Formistic	Degree of conformity to the norms of human nature and to the norm for the cultural group.
2. Hedonistic	Amount of pleasure obtained and number of ways pleasure is obtained.
3. Contextualistic	Number of voluntary vivid affective responses to situations. Intensity of affect. Optimal presence of conflict.
4. Organistic	Consistency and harmonious integration of personality features, with maximum freedom from unconscious distortion of motivation, perception and behavior.

these relatively adequate philosophies. This view holds that the greatest value inheres in whatever is closest to the "normal," and that whatever would be satisfying to a normal, healthy man is of value. Thus disease and distortion, or eccentricity, would be of less value than health and normality. Normality can be viewed in terms of the species, or in the case of patients, in terms of general universal human normality, rather than in terms of accidental or detailed aspects of personality; this corresponds in a way to the degree to which the patient approaches the common-sense ideal of "human nature." In addition we can evaluate the approach of the person to the norm of his particular cultural group. While formistic criteria of value may seem to be self-evident, it should be noted that, on a practical level, in psychiatry, deviation from "normality" is used often in determining the severity of illness, and, furthermore, that normality in a given culture has survival value, a value which has certainly entered into formation of the norm in the first place. Consideration of greater or less conformity to a norm is sometimes lost sight of in our clinical evaluations, or is undertaken intuitively. Yet in one sense, this hypothesis is the basis for the first question usually asked in evaluating progress—whether the symptoms of the presenting complaint have disappeared or become less troublesome.

The second relatively valid philosophy to be considered is that of hedonism, called by Pepper[2] the mechanistic point of view. According to this view, as applied to the aesthetic field, the goodness or worthwhileness of an object inheres in the absolute amount of pleasure which can be obtained from the object. Application of the hypothesis to the evaluation of personality leads to conclusions on the basis of how much pleasure is obtained by the person under consideration. Two aspects of hedonism are involved. First there is the total amount of pleasure the person obtains and second, one wishes to know how varied and numerous are the ways in which he can obtain pleasure. One wishes to know the extent to which maximum attainment of these pleasures has been approached by the person. It will be seen that this has a relationship to the "assets" of the personality, to the number of interests, and to the ease of relaxation and enjoyment. This procedure involves a process of identification with the person under consideration; instead of evaluating the pleasure given by the personality to the observer, as one would judge a painting for instance, one

evaluates the pleasure available to the person, or his potentialities for obtaining pleasure in the interval under consideration.

In this connection it seems best to avoid the usual objection to hedonism that pleasure of the immediate type need not lead to happiness in the long run. It is understood that immediate pleasure may be put aside in favor of later pleasure. Objections that tragic values cannot be understood on a hedonistic basis also seem best avoided at this juncture; tragic values are best understood under another frame of reference, that of pragmatism, which will be considered later. An ability to obtain simple, as well as complex, pleasures, the enjoyment of instinctual satisfactions, the number of avenues to such pleasures and the intensity of immediate enjoyment of pleasures would constitute criteria on which an evaluation can be based of the status of the personality according to this approach.

Such an evaluation can be relatively quantitative in terms of some other time in the person's life, or according to cultural and social standards of the group to which the person belongs. Underlying causes of the presence or absence of the sense of pleasure are not pertinent here; what is needed is an estimate of the number of ways the person obtains immediate pleasure, and the degree of such pleasure. Existence of evidence that pleasurable activity occurs unconsciously, as in dreams or in fantasy and in associations, is pertinent as giving indications that pleasure exists within the personality.

A third relatively valid philosophy is that of pragmatism. This hypothesis results in what Pepper calls contextualistic criteria when applied to aesthetics. In this view, great value is to be found in the experiencing of things or events. As applied to personality, one wishes to know if there is optimal intensity and depth of feeling. These considerations revolve around the common psychiatric topic of affect, and the general matter of emotional status. One is not primarily concerned here with whether the feelings experienced are those of pleasure or pain, as in the hedonistic view, but only that there be optimal feeling experienced, of whatever type. The concept of aesthetic distance may be applied; it is desirable that the intensity of emotion should not be so great as to result in disability or withdrawal. One wishes to become aware of, and to eliminate, whatever barriers there might be to full and vivid feeling in the patient's everyday life. It is within the frame-

work of this philosophy that we can understand the worthwhileness of sadness and tragedy, remembering that the intensity of experience should not be so great as to lead to withdrawal and numbness.

Sensitivity of feeling, the capacity for emotional response to others and to the environment generally, is a component criterion of this philosophy as applied to the evaluation of personality. It has been suggested by Pepper that the material falling within this approach be restricted to voluntary vivid intuitions of quality, in order to exclude involuntary painful experiences. In any case, the emphasis is upon the richness and intensity of experience. As an organized set of criteria for evaluating personality, it will be seen that this hypothesis is concerned with the situation rather than entirely with the environment or with the person alone; thus comes the term "contextualistic." Vividness and richness of experiencing within a situation is, then, to be looked for. The hypothesis directs attention to the situation, as well as to the person, and provides a needed check upon the tendency to consider a person within a vacuum or without reference to the immediate environment in which he lives. Another aspect of the pragmatic or contextualistic approach to personality evaluation is tolerance for conflict. Conflict is of value in view of the richness and intensity of experience which may be reached through it, provided the conflict does not exceed an amplitude beyond which value decreases, aesthetic distance is not sufficiently maintained, and disability ensues. In other words, in this view it is desirable for a person to be emotionally involved in conflict of an intensity below a critical level. The presence of rigid adherence to routine, excess practical activity, and excess analysis, all of which reduce the enthusiasm and affective response in situations, needs to be considered.

Finally there is the organistic approach, the philosophy of objective idealism, in which is stressed coherence and internal relatedness. When applied to aesthetics, criteria of the integration and coherence of feeling and behavior result. In terms of personality evaluation, the criteria of this world view would stress the consistency and integration of behavior, including perception and feeling. The flexible, harmonious, working together of the different parts of the personality is desired, without special reference to normality, pleasure obtained, or intensity and depth of feeling. This hypothesis, with its resulting criteria, is inclusive of optimal freedom from the unconscious motivations and motivation distor-

tions described by Kubie,[3] who stresses the point that when motivations are within consciousness, rather than inaccessible in the unconscious, adaptability to reality is furthered. One would consider most desirable a personality with a minimum of unconscious distortion of feeling, behavior, perception, and motivation. There should be an optimum—and as large as possible—amount of material within awareness, and subject to the integrating processes available for material within consciousness. In psychiatric practice the implications of this world view are commonly prominent in personality evaluation; the criteria of internal relatedness and coherence of things, when expressed in terms applicable to personality, touch upon the modern interest in motivations, upon the unconscious factors in behavior and perception, and upon the balance and imbalance of psychodynamic forces. From these considerations can emerge an evaluation of the efficiency level at which the personality is operating, as well as a comparison with other moments in the person's life. A judgment of actual performance and value as against possible performance and value can be made.

In summary, when four major criteria—normality; pleasure obtained; richness of experience and response to situations; and the optimal integration and harmonious working together of personality factors—are applied regularly in the process of personality evaluation, there is good probability that the full range of pertinent data will be considered in the light of what have been found the most useful and relatively valid methods of handling the type of information ordinarily found in everyday clinical personality evaluation. A combination of these four relatively valid criteria may serve to prevent too great diffusion, or excessively narrow concentration on one or another aspect of personality.

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DELUSIONS OF MULTIPLE PREGNANCY IN PSYCHOTICS

BY MARIANNE WALLENBERG-CHERMAK, M. D.

Delusions of pregnancy are frequent, well-known occurrences in psychotic women. Little known is the fact that in most of these cases the delusion is centered around multiple births, mostly of twins or triplets. A similar delusion is the idea of having already given birth to twins.

Among the new admissions of the last few years at Manteno (Ill.) State Hospital, 42 psychotic female patients with imaginary pregnancy or delivery have been encountered. Women in whom ideas of pregnancy were rational ones, and in whom possibility existed, were not included.

Twenty-seven patients thought they were pregnant, despite normal menstruation and other negative signs. Most patients in this group were schizophrenics and in the childbearing age. Of these, nine felt certain that they were carrying twins, 11 believed that they were pregnant with twins, triplets or more. One patient said she felt "two kicks," but was not sure if this meant she was to have twins. A young unmarried girl believed herself pregnant with "one and a half babies."

Only five patients believed that they were to give birth to *one* child. Some of these five present an interesting aspect: One had actually had twin boys, one of whom had died, and her mother was a twin; another had been told by her physician during an actual pregnancy that she probably would have twins, since she was so big, and since there were twins in her husband's family. Thus, one can see that the twin fantasy in delusional pregnancies was not present when there would have been good reality reasons for it. There were no multiple births reported in the families of all other cases, with the exception of one patient who had had a twin sister.

A second group of 15 female psychotics had the delusion of already having given birth to twins. One patient of this group thought she had had triplets; one imagined falsely that she had two little boys, one year apart; and one thought she had delivered quintuplets. Many of these patients were around the involutional age; some were younger schizophrenics. One was 68 years old and showed signs of organic brain disease. A number of these women actually had one child, but were convinced that they had

delivered twins, one of whom had been stolen, exchanged or given away. They became a nuisance to agencies, neighbors and hospitals by their constant looking for the lost children.

An attempt was made to determine whether the imagined sex of the allegedly expected, or already produced, multiple progeny was of any significance. However, there did not seem to be any rule. Some patients said they had, or expected to have, twin girls, others twin boys; in some cases of triplets the combinations given were either two boys and one girl or vice versa. Some were not quite clear themselves as to what the combinations were. One could not give the sex of the imagined fetuses but stated: "One says 'I love you,' the other 'terrible.' "

Finally, there were two male patients in whom delusions of pregnancy were rather pronounced. Both were schizophrenic, one colored, one white.

The colored man firmly believed that "the Mother of God" had handed him twins who then were being carried in his girlfriend (who was not pregnant at all). He thought *he* was pregnant through her. Drawings of the expected twins showed them to have mutilated limbs; and, verbally, he expressed the opinion that they would be crippled.

The other male patient, a white middle-aged man, had harbored for years the idea that he was pregnant. (Impregnation allegedly took place orally, through bread from a baker.) Questioning revealed that he was sure there was "more than one" baby in his abdomen. Nothing could shake this belief. When confronted with the fact that "it has been so long now" (several years), he merely said, "It's different in men." He believed he would be delivered by cesarian section "when the time has come."

The delusion (not fantasy) of having a twin sister or a twin brother was found only four times; and four patients thought they had two vaginas or two wombs. Several of these patients also had multiple pregnancy delusions and are included in that group.

It should be mentioned here that two severely psychotic young women (not included in the foregoing groups) who had made successful homicidal attacks upon their children, had firmly believed during their pregnancies that they were going to have twins.

There were two patients in whom the delusion involved quintuplets. Both were in their 20's. One thought herself to be pregnant with quintuplets and believed she would give birth to five dif-

ferent races, the fifth being newly created. This patient lost her delusion within a few months.

The other patient thought that during her actual delivery of a girl she had given birth to five children, the Dionne quintuplets, and that only one of the five had been given to her. She named her little girl Diane and spent years roaming around looking for the other four. She was overprotective of her daughter and constantly feared she would be kidnaped. Despite this, she later abandoned her, and on another occasion tried to kill her. For years, her delusion that she was the mother of quintuplets remained the same.

As one sees in these last two cases, the symptom was quite variable. In some cases, it persisted for years, even if the patient was otherwise making an apparently satisfactory adjustment. In others, it was fleeting and only one of many other delusions; it disappeared or became distorted. Generally speaking, the idea of having given birth to twins was less easy to shake than the delusional pregnancy.

In some of the cases, the alleged babies were not entirely well-developed, as in the case of the colored man. In the rather grotesque-sounding case of the patient with the "one and a half babies," one could easily explain the "half child" by the fact that the patient had a younger half-brother when she was small but never saw him.

An attempt was made to find a general pattern in the patients' longitudinal (e. g., early) life history, with reference to nursing, parent and sibling relationship, etc. Generally, it was noted that there seemed to be an early absence of a father figure (through death, divorce or desertion) and consequent domination by the mother figure, combined with strong oral frustrations. However, it must be said that this pattern is frequently seen in the case histories of psychotics anyway; and, therefore, one must be careful not to attribute too much significance to it in explaining such a complex symbol.

It is not in the realm of this paper to explore all the possibilities and dynamic connections of the twin symbol. Obviously, this is a very complex mechanism, about which a great amount of literature already exists. Myths and religious writings in all countries deal with this theme. Doubtless, the "archaic thinking" of the schizophrenic revolves around the same unconscious emotions and dy-

namics that originated those traditional stories. The Old Testament tells of the twins Esau and Jacob battling within their mother, Rebecca. The conflict between twins within the mother's womb has been psychoanalytically interpreted as the fight for possession of the mother (the first born is the one who "opens the mother's womb," according to the Bible). In the foregoing, a patient was mentioned, in whom the twin fantasy represented ambivalent feelings: Her ambivalent attitudes are fighting to see who will win the mother over. (It should be said that in this particular patient's case the hostile impulses only too often were stronger than the loving ones: She was assaultive and several times injured other people's eyes.)

The writer is aware of the phallic symbolism of triplets, and believes that, at least the delusion of having twins and triplets is an identification with the phallic mother who has breasts and the male genitalia.

The writer does not know if in pseudocyesis of the hysterical type a general pattern similar to that outlined in this paper occurs. It would be interesting to study such cases from this standpoint. As far as the psychotic is concerned, the delusion of multiple pregnancy or delivery is surprisingly frequent and is probably an overdetermined symbol.

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SEXUAL CRIME, ALCOHOL, AND THE RORSCHACH TEST

BY ZYGMUNT A. PIOTROWSKI, Ph.D., AND DAVID ABRAHAMSEN, M. D.

It has been postulated since ancient times that behavior in a drunken state is related to personality structure. Although the question of this relation is mentioned repeatedly in psychiatric literature, an experimental approach to the problem is still lacking.[1] The purpose here is to contribute to the solution of this question by means of an experimental technique, the perceptanalytic Rorschach test.[2, 3] This investigation was conducted with imprisoned and sentenced sexual offenders. Of 100 offenses known to the police, only about 3.5 lead to prison sentences.[4] Therefore, the writers' group may be highly selected, and the writers are not in a position to evaluate the process of selection accurately.

In close agreement with results of other and larger statistical surveys,[5] a previous study of sexual offenders revealed that about one-half of them were chronic alcoholics and that more than half of their offenses were committed in a state of intoxication.[6] This does not mean that all the crimes of the chronic alcoholics were perpetrated in a drunken state, or that all the crimes of the non-alcoholics were committed in a sober state. However, more alcoholics than non-alcoholics were drunk at the time of their offenses. Since few delinquents commit crimes both in sober and drunken states, the problem of the difference between sober and intoxicated conduct is important practically as well as theoretically. In many instances, alcoholic intoxication undoubtedly was an essential contributory cause in the sense that the crime would not have been committed had the offender remained sober; such offenders had no record of offenses perpetrated in a sober state. In the case of alcoholics who committed their offenses when they were sober, it was a question of alcohol consumed by criminals and not of crimes committed by alcoholics.

Alcohol does not always release the "id." This observation was made in writing as early as Seneca in Rome. The id is said to be asocial and amoral. A certain percentage of people, roughly one-fourth, become more quiet, more restrained and more considerate of others under the influence of alcohol. Therefore the id-release theory is unsatisfactory. Immanuel Kant's eighteenth century definition of intoxication is rather exact: Drunkenness is the unnatural state of inability to organize sense impressions according

to the laws of experience. It covers also those persons in whom drunkenness with its lowered self-control engenders an increase of anxiety which, in turn, inhibits motor action, leading even to sleep in some cases. In the great majority of people, personality traits related to deeply embedded urges manifest themselves in overt behavior more easily when the individual is intoxicated. The problem is: Will the individual become more or less active, more or less exuberant, more or less aggressive, under the influence of alcohol? Of course the amount of alcohol consumed is essential to estimates of behavior. The writers have no measures of the degree of intoxication of their subjects. They know that this degree varied from offender to offender in the intoxicated group. Most of them probably were not heavily drunk, because they possessed enough control to influence their unprepared partners and to perform sex acts.

In an attempt to throw light upon the relation of crime to alcohol in this investigation, two types of reactions on the Rorschach test were made use of, the human movement response and the animal movement response. The main thesis is: If a person's M, or human movement responses, are more active and more expansive than his FM, or animal movement responses, he is likely to behave in a more restrained manner when intoxicated, and consequently, if so inclined, he is more likely to commit any offense in a state of clear consciousness, i. e., in a sober rather than in an intoxicated condition. On the other hand, if the FM are more expansive than the M, the individual is more expansive and thus is more likely to commit an offense in a state of diminished consciousness, i. e., in an intoxicated rather than in a sober state.[7]

The search for a thesis of this kind was motivated by the incomplete explanation of the psychological significance of the FM, or animal movement.[8] Rorschach himself merely mentioned the occurrence of animal movement responses but did not assign to them any specific meaning or a separate symbol.[3] Many authors still classify the animal movements with mere form responses. Piotrowski suggested that the FM indicated the basic attitude which the individual assumed when dealing with others in personally vital matters during his early childhood. M was defined as indicating the basic attitude utilized not in the past, but in the present.[8] It has always seemed that the psychological traits tapped by perceptanalysis would not point to the past if the past, reflected

in the FM, were of purely historical significance. It seemed much more probable that all the personality traits revealed by the Rorschach must have some significance for the present.

Research with sexual criminals led to the discovery of the possible meaning of the FM for the present. The attitudes shown in the FM originated in the early past but they still have an actual and practical significance which consists in influencing overt behavior directly during states of diminished consciousness.

For the moment, one may disregard the numbers of M and FM and consider only their quality. Not every inmate produced both M and FM, consequently the thesis was not applicable to all offenders. Another limitation was imposed by the unwillingness of a number of inmates to describe their conditions at the time of committing their crimes, and the incompleteness of the records regarding this point. Many inmates seemed in doubt as to whether commission of a sexual offense in a drunken or a sober state was the more aggravating circumstance. The authors mean by "intoxication" a state of diminished consciousness or of weakened integration brought about not only by alcohol but also by drugs, extreme fatigue and acute anxiety.

One serious question must be raised and be left unanswered: How valid and reliable are Rorschach examinations when done after the commission of the offense, sometimes years later? The writers proceeded on the assumption that the personality traits reflected in the Rorschach by the movement responses do not change sufficiently to distort the present conclusions. The M are, as a matter of fact, the components which resist change most vigorously.[2] The FM probably are similar in this respect. It is well known that psychological examinations are difficult to perform immediately after a crime and before trial. The accused's tension then is usually so great that one rarely gets truly reliable or sufficiently ample findings. The findings at such a time are also frequently distorted by the advice which the accused has received from his lawyer, especially if the latter wants to base his defense on the claim of temporary insanity.

The estimate of the amount of active and expansive movement indicated in the M and FM can be made by direct comparison of the M with the FM. These estimates can usually be made directly but require experience if they are to have a satisfactory degree of reliability. A scale has been developed to make these estimates

more uniform and more reliable. This scale consists of different degrees of freedom and expansiveness of movement. Application may entail some loss in validity because it is difficult to fit every movement response into one of the five degrees of the scale. Some significant nuances have to be neglected to make the scale practicable.

The scale is built according to the principle of decreasing amount and decreasing freedom of overt movement and applies to the animal as well as to the human movement responses.

Degree 1. *Aggressive Movements.* Every response which expresses clear aggression belongs in this category. Examples are "men fighting," "women turning noses up at each other," "man ready to strike with a club." It does not matter whether the entire organism or merely a part of it is "seen"; this is one of the nuances which are overlooked for the time being. The aggressive act or aggressive intention is the decisive element. "Insects eating away flowers" also has been classified as an aggressive act, because this response indicates destruction of the flowers.

Degree 2. *Whole Body Movement.* In this category, belong all responses in which whole bodies, human or animal, are involved in active motion, i. e., movements in which the effect of the force of gravity is overcome without any clear suggestion of aggression. Examples: "man drifting out of Alladin's Lamp," "walking," "bear climbing," "tiger crossing a stream," "dancing." In this type of response the whole body must be moving in space and must assert itself against the downward pull of gravity.

Degree 3. *Body-Part Movement.* This type of response should include movements counteracting the force of gravity but performed only by a part of the body. The subject may see the whole body but with only one part of it involved in the counter-gravity movement, or he sees only parts of the body engaged in this kind of motion. Examples: "women talking over the back fence," "pointing finger," "animal raising its head," "foot kicking," "head of a person looking up," "a woman holding an object and keeping it from falling."

Degree 4. *Restrained Movement.* This category includes postures and movements that are forcibly restrained. Again it does not matter whether the whole body or part of it is seen in this type of movement. Examples: "man with legs and hands tied together,"

"man standing at attention," "animals with horns tied together," "a woman standing still," "an animal on the alert."

Degree 5. *Compliant-Passive Movement.* Responses which belong in this category contain whole bodies or parts of them in the process of giving in passively to the force of gravity or submitting actively to the influence of others. Examples: "man bowing," "woman falling through the air," "bowed head," "people sleeping on the hillside," "cows resting on the grass," "dogs sleeping," "a child kneeling," "a dog begging." These movement responses have not been subdivided according to whether they are associated with tension and/or with relaxation. This is another nuance which is disregarded at present. The psychological difference between the meaning of an actively compliant M (e. g., people bowing) and a passive or retiring M (e. g., people sleeping) is great. The latter indicates a strong desire for withdrawal from active interrelationships with other people, and readiness for a passive sufferance of what life might bring. The actively compliant M points to a strong desire for being psychologically supported or led by others but it signifies also an active interest and readiness for participation in mutually meaningful human relationships. However, the scarcity of the passive and indolent M in the authors' group of subjects made it inadvisable to provide a separate category for the passive M. At any rate both the actively compliant and the passively retiring movements are less expansive in intent than are the movements in the preceding four categories.

It should be kept in mind that the essential criterion of movement in the Rorschach test is a change in kinesthetic innervation. The test is psychological and not physical. Thus, psychologically the act of imagining someone motionless in a coffin may be associated with a distinct kinesthetic sensation, and therefore, would be classified as a movement response on the Rorschach test. A definite change in the muscular tension of a living individual is needed for him to have a vivid image of complete lack of movement. Whenever any change in kinesthetic innervation can be ascertained, Rorschach responses are scored as movement responses.

The authors' thesis is that if the human movement responses are more expansive, more free and more active than the animal movement responses, the person is likely to behave more aggressively in a lucid state than in a state of diminished consciousness (weakened integration). On the other hand, if the animal movements

are more expansive and freer than the human movements, then the individual is likely to behave more aggressively in a state of diminished consciousness (weakened integration) than in a state of lucidity, sobriety, and good integration.[7]

Lucidity of consciousness and conscious self-control are diminished by the consumption of alcohol, by drugs, by a sudden and great inner tension, by powerful emotions, by great physical fatigue, and by psychotic episodes. In nearly all of the present cases, the diminution of consciousness was brought about by alcoholic intoxication. Of course, several of the factors listed in the foregoing can act together to lower control over actions and lucidity of mind.

The scale is not applicable when there is no difference between the quality of the M and of the FM, or when either M, or FM, or both, are missing. The writers had to go through 134 consecutive records before they collected Rorschach records of 100 sexual offenders who produced both M and FM of varying qualities. Very many people produce M and FM of several kinds, belonging to different categories of the scale. The decision as to whether the M or FM were the more expansive responses depended on the degree of freedom, activity, and expansiveness of movement. The degree 1 responses are the most active, expansive and free. The degree 5 responses are at the opposite end of the scale. If any of an individual's M belong to a more expansive category than any of his FM, the individual can be said to have more expansive M than FM, and vice versa. Using this statement as a rule, no difference between the M and the FM was said to exist when the most expansive FM and the most expansive M belonged to the same degree on the scale. Such cases were excluded from the present investigation. The difference was described as small when there was a difference in scale placement between the most expansive M and the most expansive FM and when the distribution on the scale of the remaining M and FM of the same subject overlapped completely (Table 1). The difference was said to be medium when the most expansive M and FM differed in placement on the scale and the overlap of the remaining M and FM was only partial. This was the case when both the most expansive M was placed higher on the scale than the most expansive FM, and the least expansive M also was higher on the scale than the least expansive FM—or vice versa. The difference was described as great when all of the M were

placed higher on the scale than any of the FM, there being no overlap at all between the distribution of the M and the FM on the scale—and vice versa.

Table 1. The Degrees of Difference Between the Expansiveness of the Human Movement and Animal Movement Responses on the Rorschach

	Degrees of Movement on the Scale					
Examples of great difference between M and FM	(1)	(2)	(3)	4	5	M
	1	2	3	(4)	(5)	FM
	1	(2)	(3)	4	5	M
	1	2	3	4	(5)	FM
Examples of medium difference between M and FM	1	(2)	(3)	(4)	5	M
	1	2	(3)	(4)	(5)	FM
	(1)	(2)	3	4	5	M
	1	(2)	(3)	(4)	5	FM
Examples of small difference between M and FM	(1)	(2)	(3)	(4)	5	M
	1	(2)	(3)	4	5	FM
	1	2	(3)	(4)	(5)	M
	1	2	3	(4)	(5)	FM

The scale placement of the most expansive M and FM was selected as the main criterion—not the average placement of all the responses on the scale. The M and FM indicate basic attitudes which the individual tends to assume when dealing with others in personally vital matters.[2] The chances of the basic attitude being realized in actual conduct vary with the significance of the social situations facing the individual, with his anxiety, and with the variety and intensity of other "basic attitudes," indicated by the other M or FM produced by the same individual. The greater the variety of the M or FM elicited from the same person, the less frequently will a particular attitude influence directly the person's interpersonal relationships. It must be remembered that the Rorschach method gives an inventory of possible behavior patterns; it gives a survey of motivations and attitudes of which the individual is capable. At different times, the person activates different potentialities, rarely if ever activating all of them at once. Similarly, the offender, especially the sexual offender, does not behave in a criminal manner at all times, but intermittently, and sometimes after long intervals of noncriminal conduct. For this reason, it is important practically, as well as theoretically, to know whether a

person is likely, ever, to behave more aggressively in a sober or in a drunken state.

The main thesis applies to noncriminals as well. The noncriminal person, too, would be expected to be more active, expansive, and outgoing in a state of diminished consciousness if his FM are more active and expansive than his M. It seems to be true in general that the differences between criminal and non-criminal behavior are those of degree, rather than of quality.[9]

Traits signified by the M are deeply embedded. Aggression manifested in the M always points to deep and not easily modified aggressive trends; an individual with aggressive M is one who is deeply convinced that aggression and struggle with others are inevitable if one is not to perish. Such individuals would take a violent acting-out as a matter of course. One type of an undesirable M or FM which the writers have found more frequently in the violent offender groups than in any other belongs to degree 4 on the scale. This M or FM is of a particularly frank sado-masochistic character; tied and bleeding people or animals which have been mutilated and struggle in vain for release from their bonds. The histories of individuals producing such movement responses have disclosed that they were exposed to very heartless, cruel and frustrating treatment on the part of their parents and others and have built up such intensive resentment that it sometimes breaks into overt behavior; such individuals have periods of an explosively ruthless and violent activity accompanied by a complete disregard for others and usually also for themselves. Alcohol can be disastrous to such a person because it can make him act violently, all of a sudden, toward persons with whom he may be getting on fairly well ordinarily. It is understandable that such a person would, in drinking, seek relief from the great inner tension caused by repressed resentment and a humiliating feeling of abject and fearful submissiveness to those who treated him heartlessly and harshly.

Lewis found that those who become sadistic under alcohol are likely to be epileptoid.[10] The blocked human movement responses of the present inmates, in which figures are tied and frustrated, symbolize well the epileptoid's chief need of preventing an outbreak of uncontrolled and violent activity. The most desirable M is one in which the whole body is felt to be in a free, spontaneous, nonaggressive, and nondestructive motion. Such a "healthy M" belongs to degree 2 on the present scale. The degree 3 movements

are less desirable because they imply inhibition. The passive movements of degree 5 are least desirable for they indicate a deep-seated lassitude and inactivity, with no inclination to participate in interpersonal relationships. They denote inertia.

When the sources of information regarding the inmates' state of consciousness at the time of the offense were not contradictory, the writers assumed that the information was reliable. In a number of cases the inmates' own statements were the only source of information. The reliability of these statements was checked by inquiring several times at long intervals about sobriety or inebriety during the perpetration of the offensive act.

The inmates were classified into five categories, in accordance with the degree of agreement or disagreement of their perceptanalytic responses with the main thesis. The five categories have been defined as follows:

Full agreement of the Rorschach findings with the writers' thesis was said to exist (1) if the M were the more expansive in case the offense had been committed in a state of sobriety, or the FM were the more expansive in case the offense had been committed in a state of intoxication, and (2) if there was a great difference (see foregoing definitions of difference) between the M and the FM of the inmates (Table 2). Good agreement between the Rorschach and the thesis was said to exist (1) if the M were the more expansive in case the offense had been committed in a state of sobriety, or the FM were the more expansive in case the offense had been committed in a state of intoxication, and (2) if the difference between the M and the FM was medium. Partial agreement was said to exist (1) if the M were the more expansive in case the offense had been committed in a state of sobriety, or the FM were the more expansive in case the offense had been committed in a state of intoxication, and (2) if the difference between the M and the FM was small.

Partial disagreement between the Rorschach findings and the main thesis was said to exist (1) if the M were the more expansive in case the offense had been committed in a state of intoxication, or the FM were the more expansive in case the offense had been committed in a state of sobriety, and (2) if the difference between the inmate's M and his FM was small. Complete disagreement was said to exist (1) if the M were the more expansive in case the offense had been committed in a state of intoxication, or the FM

were the more expansive in case the offense had been committed in a state of sobriety, and (2) if the difference between the M and the FM was medium or great.

Table 2. Degrees of Agreement Between the Main Thesis and Rorschach Findings in the Case of 100 Men Convicted for Sexual Offenses

Degree of agreement	Sober	Drunk	Total
Full agreement	8	26	34
Good agreement	8	11	19
Partial agreement	12	19	31
Partial disagreement	7	0	7
Complete disagreement	7	2	9
	42	58	100

There were 84 men in the three categories of agreement. Thus the thesis was fully or partially confirmed in 84 per cent of the cases. Many men produced human and animal movements with varying degrees of activity and expansiveness. This resulted in several degrees of agreement between the thesis and the Rorschach findings. Fifty-eight men were drunk and 42 were sober at the times of their offenses. In general, more offenses are committed by drunken alcoholics than by the sober nonalcoholics.[5] The thesis was confirmed much better in the drunken than in the sober group, the former showing a much smaller percentage of exceptions to the thesis. This may be an advantage as far as predictability of conduct and parole are concerned. The men who were intoxicated are, as a group, less stable and more tense than the sober group. Furthermore, self-control is usually lowered under alcohol; and, therefore, ungratified personality needs, such as are indicated by the perceptanalytic animal movement responses, are more likely to affect overt behavior in a drunken state. The fact that so many offenders need to become intoxicated before they perpetrate offenses shows that they must change and become different from their usual selves before they can act offensively.

Alcoholic intoxication affects voluntary control over the muscular system, decreasing the skill with which actions are executed and facilitating the release of impulses. However, from the standpoint of prevention of violent behavior, the decrease in the skill of motor performance is much less important than is the kind of impulse released by intoxication, i. e., the change in attitude toward

people which takes place in a state of drunkenness. Therefore, alcohol presents a much greater danger to the inmate's future and to the safety of his fellow-men if the inmate tends to become more active or even violent under alcohol. Furthermore, it seems that the man who behaves more aggressively when drunk has more severe personality difficulties than the man who becomes less aggressive under alcohol. The FM was defined as an indicator of a basic attitude which developed very early in life—earlier than the M. If this is so, the existence of disturbed FM in a Rorschach record implies that the severe frustrations and the habit of violence started in the first years of life. Other conditions being equal, unfavorable personality trends that started earlier in life would affect the whole personality development more definitely than trends which appeared later in life.

The writers' thesis should be checked with a new group of subjects in order to be more certain of the extent to which it helps to predict the change in attitude toward people in a state of intoxication. The prognosis of those inmates who are likely to become more aggressive under alcohol and who are alcoholics is poorer than is that of those inmates who become less aggressive when inebriated. Drinking is an escape from inner tension. One might express this statement in perceptanalytic terms by saying that the apparent (unconscious) purpose of a drinker is to weaken the influence of his M and to intensify the influence of his FM. As "the organism is at all times operating under the evolutionary guidance of two great forces, i. e., the reproductive and the destructive drives,"[10] some of the FM tendencies are mainly destructive and others mainly reproductive. The reproductive drive would manifest itself in acts of affection and attraction, while the destructive drive would be recognized by acts of rejection and hostility. The FM tendencies, which originated presumably at a time when the personality of the man was less integrated than when he developed his M tendencies, can influence overt behavior more easily when the integration is weakened by alcohol or other agents. The FM are echoes of the past which still lives on, but does so in a less developed form. This past must be pleasant if the man craves a return to it. The pleasantness consists probably of a state of greater inner freedom, and not in the quality of the drive released by alcohol whether it be destructive or reproductive.

SUMMARY

A thesis has been presented which holds that persons who produce more expansive and more spontaneous human movement responses than animal movement responses on the Rorschach are likely to manifest a less expansive, less free and more retiring attitude toward others when they are in a state of diminished consciousness, or weakened integration, despite the lowered skill in motor performance and lowered self-control. On the other hand, individuals who produce more expansive and more spontaneous animal movement responses than human movement responses are likely to display a more active, and at times a more aggressive, attitude toward others when in a state of diminished consciousness. This thesis was applied to Rorschach records of 100 imprisoned sexual offenders. It was found that the thesis was confirmed in 84 per cent of the cases. As far as parole and future adjustment are concerned, it is important to know whether a prison inmate tends or does not tend to be more active and more aggressive when he is under the influence of alcohol or other agents diminishing consciousness. Alcoholism combined with a tendency to commit offenses in a drunken state is worse than alcoholism combined with a tendency to commit offenses only in a state of sobriety. There is more hope for nonalcoholics committing offenses when drunk, because the personality of the alcoholic is far less changeable than that of a nonalcoholic.

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SOME THOUGHTS ON THE RELATION OF RELIGION AND PSYCHOLOGY

BY HIRSCH LAZAAR SILVERMAN, Ph.D.

More and more do we find increasing interest in the relation of religion to psychology and to personality.[1] One of the first in the last century to give deliberate study to the varieties of religious experience with a view to discovering some of their sources was William James.[2] Since the 1890's, Coe,[3] Starbuck,[4] Leuba,[5] and Pratt,[6] among others, have helped to create an interest in, and an attitude of wholesome questioning concerning, the characteristics which make up the religious life and background of the individual.

There is now a decided popular interest in the psychology of the religious life, based in part on the development of psychological science generally, with its application to all phases of life, and especially in terms of personality integration and social adjustments.[7] The foregoing considerations induce psychologists and educators to ask which environmental and experiential factors are significant for the adult personality and for religious background and life. It is worth noting that even in the history of the psychology of religion, some philosophers, like Comte, sometimes formulated a variety of humanistic mysticism and transformed it into a complex "religion of humanity," replete with ceremonies, sacraments, priests and temples.[8]

In the preparation of the present essay, the question of life patterns as partial determinants of religious differences deserves consideration. While an individual conforms to the spirit of religion through what he has been taught to be and to do, and in his ways of acting generally, the present writer feels there are other factors which enter into the determination of religious background, and other ways in which such background affects personality.

As Murphy[9] indicates, religion falls into several categories: It has much to do with marriage and the family, with the arts, and with the self-regulation mores. Johns[10] points out rightfully that adults differ greatly in their religious attitudes; yet, he indicates that there is a general nature of religious experience. Dorsey[11] finds religion an important factor in behavior hygiene. To him, "Religion has biologic value for the person. Prayer is helpful work."

I

The "psychology of religion" is a scientific description of the religious consciousness and of the laws underlying its action. As a branch of general psychology, it seeks to collect the facts of the religious consciousness, systematize them into a scientific description, establish laws of sequence between them, and if possible explain them by the application of various general principles. The methods of the psychology of religion are two-fold: (1) collection of data; and (2) systematization of data.

This the writer has considered in this essay by first recognizing three separate factors: 1. *Celebration*—the social observance and public worship in appropriate ritual form, of the values to which a group is devoted; 2. *Consecration*—the co-operative dedication to those values; and 3. *Clarification*—the reflective criticism and appraisal of their significance and worth in the individual's life.

The meaning of religion, psychologically, is comprehended in man's worship of God and his service to other men, in breathing a new spirit into man's quest of truth, putting into individuals a center and source of moral authority and moral dynamic, which safeguards character and gives it direction, furnishing education with a sense of values which keeps man's knowledge in tune with the things of life that are worth while.[12] "Millions of Americans believe that no one can be fully educated who is ignorant of the great Hebrew-Christian heritage, and that the times call for *more* religious education, not less"; and "Americans are deeply interested in a spiritual interpretation of life. . . ."[13]

When it is held that religion is essentially an attitude, the writer means, by use of the word "attitude," the reflection of the individual on the ultimate result of man's living. Religion means, then, analyzing one's self as believing in life; and the difference between religion and theology lies in the idea that religion is a practice in reality, and theology is a study. And further, the difference between religion and morality is that religion is judgment by one's self, while morality is the standard of judgment others use toward one as an individual in society.[14] Psychology in religion, in terms of personality, describes the workings of the human mind and the attitude toward religion, since "an individual's religion is composed of his background and his social relationships."[15] It is to be pointed out in this context, too, that man's "religious consciousness" is an expression within individuals that

helps bring out the religious feelings within them, which consciousness is derivable from sermons, prayers, etc.[16] In short, religion emanates from the individual who, as a member of society, receives from this society the basis of his religious attitudes psychologically.

Religion and psychology, both dealing with the outward reaching of man's mind and the advancement of mental health, are not hopelessly at odds.[17] The underlying point to be stressed is the subjectivistic right of the individual to work out his own philosophy and to find his own place in creation. We must see clearly the forces of culture and conformation which invite us to be happily content with religion, uneven as it is perhaps at times.

We must, at the same time, observe intimidation by narrowly-conceived science, teachings and writings which tend to discourage the religious quest. Religion in many lives may be only symptomatic of fear and frustration; but this is its function only for the infantile and neurotic personality.

Religion is not on its way out certainly, although some scientific writers have pushed it at times into the background. (There used to be as much written on religion as there is on sex today.) A majority of people assert they are religious; still a larger portion maintain they believe in God. Secularization has risen in other times and has not killed religion. Whatever may be the fate of institutionalized religion, personal religious sentiment is conceived to be very much alive.

Some writers have tried to find a single basic form of experience which is inevitably a part of religious sentiment, but they unconsciously project their own religious sensitivities onto the world. Most psychologists agree that there is no single religious emotion. There would seem, then, to be no single intellectualization of what constitutes a religious sentiment. However, by denying a standard form to the religious sentiment, there is by no means denied a personal form. There is, perhaps, no religious instinct; and even McDougall considers religious emotion to be a complex of many factors.[18]

Religion has been considered by some writers to be a mild form of sex sublimation or sex repression. Freud's[19] view of God as a father displacement is evidence in point. James[20] would present the hypothesis that the individual's mind is a fragment of a uni-

versal mind, as in the concepts of Hinduism and Christian Science. However, these may be purely metaphysical considerations and not psychological.

II

There are both conscious and unconscious factors at work in the development of religion; our bodily needs, our temperaments and mental capacities, our psychogenic interests and values, our pursuits of rational explanations, and our responses to the surrounding culture. These items deserve to be considered in detail, especially in the light of the contents of our religious thinking.

First our organic desires: Food, water, and shelter may become religious items. Fears of sickness, poverty, nature, ostracism, and death also create needs. Usually in the critical periods of life when desire is intense, religious consciousness is acute. Many are religious only at moments of crises. The religion of the individual brings together the mingled motives and desires of an unfulfilled life. Also, divine attributes plainly conform to our needs: When we need guidance, God is the Holy Spirit; when we need affection, God is love.

Concerning temperament, organized religion finds a place for a great variety of temperaments, but it cannot satisfy all varieties seeking satisfaction. In this respect, the Hindu practice of assigning a name for God and a mode of worship to each youth according to his desires and temperament is psychologically interesting.[21]

Psychogenic desires are aesthetic hungers. Values become generalized into goodness, beauty, truth, and holiness. Some of these are more self-centered, like power, self-expression, and adventure. Egoism becomes the most universal of all values, the value of the conservation of personal integrity. Even the value on "selfhood" may be abstracted and held as a value for all, a process which gives rise to values like charity, tolerance and equality. This is an expression of a sort of generalization of the ego: identifying with the self, surroundings, the world, and then God. Respecting the concept of selfhood, God himself may be a supreme expression of personality, a necessary and final value required to explain and to conserve all other values of selfhood. This unbiased respect for the integrity of personality whether expressed in a religious context or not, is an essential value in all psychologies. Values should not remain on the egotistic level and merely conserve self-interests, but

should be more highly abstracted and generalized as in the affirmation of the worth of personality, in order to have a broad religious character.

III

In the pursuit for meaning, to be sure, religion is a search for complete knowledge. No two individuals have the same intellectual powers or have identical intellectual difficulties, and therefore, no two have identical solutions. Religion is not a substitute for empirical scientific thinking; and "science" cannot give all the answers. Science is necessary for problems of empirical causation; religion deals with problems of adequate meaning. Each has its own area of inquiry. To the extent that the individual can find some partial or approximate solution to the problems of evil and creation, his life moves toward intelligibility and optimism. These are, for most people, seldom wish-fulfilling fantasies. Some such biases are inevitable, religious or not. Religion tends to define reality as congenial to the powers and aspirations of the individual; but so does any working principle that sustains human endeavor.

Modern religions tend to be concerned more than in the past with insuring social welfare for the living. "Religions so concerned with the real conditions that make for poverty, crime, and ill will," according to Johnson,[22] "and that are oriented to the tangible possibility of making a better social order here and now —or as soon as possible—tend to exert a positively adjustive influence."

The implications of culture and conformation, as elements in religious development, are rather obvious, then. The child adapts the living habits of his group.[23] "A child's religious ideas and images will, of necessity, be influenced by his experiences in everyday life. . . ;" and a study of the effects of religious instruction, in the words of Jersild, "would have to appraise the more subjective phenomena denoted by such terms as peace of mind, relief from guilt feelings, hopefulness, the disposition to be forgiving and patient, and the like."[24]

The religion of the young child is realistic. Children under 15 think of God, heaven, and hell, for example, in concrete terms. And the young child is reverent in his attitude toward religion, the religion of children being egocentric and self-seeking.[25]

IV

As regards culture and religion, cultures give great prominence to ritual and myth; wherever religious systems are greatly disrupted, the consequences are great, historically, unless some equivalent system of belief replaces them; religious systems are not independent of the remaining portions of culture, but are intimately integrated with them, and therefore one religion cannot supplant another without basically altering the culture. We cannot assume that religion is merely a culturally-created design, because this would mean that we all would have a religion identical with the cultural model taught to us. In fact, the social-control elements of religion are not so significant as some may suppose. Religion's function is not to produce social stability or to sanction culturally a vent for strong emotions.

It is felt, in addition, that personality becomes enhanced with religious maturity, and the writer will attempt now a definition of the attributes of a mature personality. First, psychogenic interests must be present, which of course concern themselves with ideal objects and values beyond the range of viscerogenic desires. We must escape the level of immediate biological impulse. The ability to objectify one's self must be present. We need to be reflective and have insight about life; we need a good perspective. A well-developed sense of humor is one aspect of this. We must have some unifying philosophy of life. It need not necessarily be articulated in words, or be entirely complete, but man needs direction and coherence from a dominant integrative pattern of life. Then, these elements of the mature personality are interests, detached insight, and integration; or the expanding self, self-objectification, and self-unification.

V

A sentiment, whether religious or not, involves motivation and organization or patterning. It involves both cognative and emotional elements. Allport[26] defines the mature religious sentiment as "a disposition, built up through experience, to respond favorably, and in certain habitual ways, to conceptual objects and principles that the individual regards as of ultimate importance in his own life, and as having to do with what he regards as permanent or central in the nature of things."

It should be pointed out that we must not expect our religious sentiment to be completely consistent. Its very making is always unfinished business. Even with a strong religious sentiment, we still do not find that our conduct issues as uniformly as we wish. Impulses often win out, and we do things we would not do. But the mature religious sentiment is distinguished, finally, from the immature sentiment, in that it is: 1. well-differentiated; 2. dynamic in character in spite of its derivative nature; 3. productive of consistent morality; 4. comprehensive; 5. integral; 6. fundamentally heuristic.

By its very nature religion begets strong conviction and loyalty. The more earnestly religious a man is, the more intensely he believes something and commits himself to it. Religion as a sense of the whole personality is the most individualized of all things, the most spontaneous; and giving values to life makes life more personal for each man. For only persons can value. The sense of values which religion furnishes, fills man with recognition of the worth of personality, and makes for the development of the positive and attractive qualities that psychologists think of as constituting the essence of personality.

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REVIEW OF LEGISLATION FOR THE YEAR 1952

BY MARSH BRESLIN, L.L.B.

The 175th session of the New York State Legislature, convening somewhat later than usual, began its deliberation on January 9, 1952 and concluded its activity in the early evening hours of March 20. Although advance notice seemed to indicate it would be an "off" year, more than 6,300 bills were introduced, and on the day set aside as the last one for the introduction of bills, the members set a new record by introducing more than 1,600 in one legislative day.

The Department of Mental Hygiene had 11 bills, which it was directly sponsoring, in the 1952 session, covering a variety of subjects, the most important of which were those affecting the continued occupation of Ward's Island by Manhattan State Hospital, a complete revision of the provisions for the care and treatment of epileptics, and a method for using interest accumulations on patients' funds. Generally, the session was very active insofar as mental hygiene problems were concerned, and a great number of bills were introduced that directly affected the department.

All 11 of the measures sponsored by the Department were passed, and, with but one exception, all were enacted into law. A measure relating to the requirements of qualified psychiatrists, after passing both houses of the legislature, was vetoed by the governor. No memorandum was filed with the veto, but it must be assumed that the need for the proposed changes was not fully appreciated. Legislation concerning the Department of Mental Hygiene, properly grouped under related headings, is listed herein as follows: "Appropriations," "Mental Hygiene," and "Related Statutes." All new laws or amendments may be assumed to be already in effect except as otherwise noted.

Appropriations

Under Chapters 1, 54, 56 and 161, the legislature appropriated a total of $163,865,866 to the Department of Mental Hygiene for the fiscal year beginning April 1, 1952, representing an increase of $2,143,420 over the amount allocated for the previous year. The largest appropriation included therein is the sum of $74,835,685 for personal service, representing an increase of $1,133,987 over

the sum set aside for that item in 1951. It should be noted that the total includes $1,200,000 for new positions.

For maintenance and operation, the sum of $43,362,856 was appropriated, reflecting an increase of $7,104,291 over the amount set aside by the legislature of 1951. Included among the items for maintenance and operation are the following:

$2,030,000 for the Edgewood unit of Pilgrim State Hospital,
3,200,000 for Willowbrook State School,
837,200 for the Mental Health Commission,
18,000 for the Mental Hygiene Council,
57,300 for brain research at the Psychiatric Institute,
82,000 for psychobiologic research at Creedmoor State Hospital,
24,300 for research projects at Letchworth Village; and
14,600 for research at Craig Colony.

The principal sum of $44,997,542 was allocated for capital projects in 1952. This is a decrease to the extent of $6,094,858 from the sum that was appropriated in 1951. The amount is also subject to a deduction of $2,683,400 occasioned by the repeal of certain specific allocations previously made. In addition to the appropriations listed, the specific sum of $1,100,000 was made for rehabilitation and improvements, and $1,000,000 for equipment.

Mental Hygiene

Chapters 101 and 491 of the Laws of 1952 both relate to Manhattan State Hospital and its continued operation on Ward's Island. Once more the problem arises in connection with the intent of the City of New York to develop certain parts of Ward's Island for park purposes. Chapter 101 extends the time of removal on parts of the Island for one year and authorizes both the City of New York and the State of New York to extend an existing lease for 50 years. Chapter 491 amends the Mental Hygiene Law by adding a new section, 64-a, to permit the commissioner to execute the lease set up in Chapter 101. Under the revisions, the Department of Mental Hygiene acquires additional security in tenure, so that new structures badly needed at Manhattan State Hospital may be erected.

Chapter 673 repeals the existing provisions of the Mental Hygiene Law relating to Craig Colony. It sets up a new procedure for the admission and care and treatment of epileptics, considering both Craig Colony and licensed private institutions for epileptics.

Under this revision the law concerning epileptics is now uniform, as to form and general procedural requirements, with the analogous sections of the Mental Hygiene Law relating to the mentally ill and the mentally defective.

Chapter 726 amends subdivisions 9, 14 and 17 of Section 34 of the Mental Hygiene Law. Subdivision 9 is revised by making the third paragraph new subdivision 9-a, in which the procedure on fingerprints will be required only of persons 16 years old or older, when the condition of such persons permits such prints to be made. There is no longer any duty to send photographs of patients to the central office, and copies of the fingerprints, when taken, are no longer to be processed by the Department of Mental Hygiene but are to be sent to a state agency having a central fingerprint file.

Subdivision 14 of the same section is revised by the elimination of the right to use interest on a patient's funds for his particular benefit or in payment for his care and treatment.

Subdivision 17, relating to mutual aid in fire fighting, is amended to enlarge the territory within which such mutual aid may be had, both as to the institutions and adjoining localities. Institutions may also be permitted to participate in local practice and training programs in the mutual aid plan.

Chapter 727 relates to accumulations of interest on the funds of patients, the use and proper crediting of which has been a serious problem for the department for some time. This amendment adds a new section 51 to the Mental Hygiene Law, which permits the use of accumulations of interest on patients' funds for the benefit, comfort and entertainment of patients in the particular institution by which the funds are handled. It is noteworthy that each such expenditure requires a certificate of approval from the director of the budget and the specific approval and consent of the commissioner of mental hygiene.

Chapter 598 revises Section 24 of the Mental Hygiene Law relating to reimbursement for the care and treatment of patients. By this amendment the commissioner is granted authority to establish charges for care and maintenance based on his evaluation of ability to pay. The requirement for the execution of special agreements calling for the payment of amounts in excess of the established reimbursement rate is eliminated. The amended section also permits the Department of Mental Hygiene in every case to make claim for any differential amount that may exist, by reason

of an amount less than the reimbursement rate having been charged or collected.

Chapter 399 amends Section 126 of the Mental Hygiene Law in connection with the costs of certification of a mental defective. In 1949 the costs of certification for the mentally ill were made direct county charges, and the present revision of the comparable section affecting certification of the mentally defective is now made uniform by establishing these costs as county charges.

Chapter 456 amends subdivision 5 of Section 74 in connection with certification of the mentally ill. Where the strict application of the provisions of this subdivision required the director of a state hospital to receive the certification papers before arrangements could be made for the admission of a mentally ill person, that rule is relaxed by the present revision. The director of a state hospital may now make arrangements for such admission upon receipt of notice that the certification papers have been properly completed. It should be noted that action under this authority is left to the discretion of the director.

There remain but two chapters of the Laws of 1952 with which the Department of Mental Hygiene was directly concerned. Chapter 354 authorizes the Mental Health Commission in co-operation with the departments of health and mental hygiene to formulate a program of clinics operated by public or private nonprofit community agencies or institutions for the diagnosis, treatment and rehabilitation of chronic alcoholics. Direct financial aid may be granted such approved clinics to the extent of one-half the annual net operating expense, with the approval of the director of the budget.

Chapter 475 authorizes the commissioner of mental hygiene to convey a portion of Kings Park State Hospital land, no longer required for hospital purposes, to Central School District No. 5 in the town of Smithtown, Suffolk County.

Related Statutes

Chapter 374 amends Section 4 of the Banking Law in relation to information to be given by banking organizations to public welfare officials. It strengthens the authority to seek such information and more clearly defines the actual dispensing of public assistance. It should facilitate the work of the special agents in verifying resources.

Chapter 540 revises Section 147 of the Education Law by exempting state departments and agencies from the provision prohibiting the disposal of records which are no longer in use. Prior to this amendment, it was necessary to advise the commissioner of education of the nature of the records to be destroyed and to obtain his specific consent for such destruction. Subdivision 1 of Section 6906 of the Education Law was also amended by reducing the age requirement for practical nurses from 20 years to 19, a change which should be of considerable advantage to the institutions within the department.

It should also be noted that Chapter 94 continues the effective provisions of the Defense Emergency Act. Within the provisions of this act will be found the specific section relating to the use of margarine in institutions. The need for this section is now eliminated, with the general liberalization of restrictions on the public sale and use of colored margarine.

The Public Health Law was amended by the addition of a new section, 430, relating to reports by physicians of users of narcotics treated by them. Under this revision all attending or consulting physicians are required to make prompt reports of the names and addresses of any persons under treatment when it appears such persons are habitual users of any narcotic drug. This section will affect the department; and appropriate instructions have already been given to insure compliance with its provisions.

As is usual, various measures were introduced during the 1952 session which concerned the Department of Mental Hygiene. Some 25 bills directly affecting the department were introduced, all of which were held in committee or failed to pass either or both houses of the legislature. Among those proposed which failed to be approved will be found the following:

Assembly Int. 1260, Print 1279, would have authorized the attorney general to assist in the commitment of the mentally ill and in the release of patients from state institutions. It was opposed as unconstitutional.

Assembly Int. 841, Print 846, would have permitted all residents of the state to be admitted to state hospitals, without the existing preference as to the "poor and indigent."

Assembly Int. 842, Print 847, and Assembly Int. 1111, Print 1125, would have authorized research programs concerning mental illness and mental deficiency. These were opposed as being im-

possible to implement with present personnel limitations, and on the further ground that the Department of Mental Hygiene has several research programs in progress under the supervision of the Mental Health Commission.

Assembly Int. 1790, Print 1842, would have established special wards within mental hospitals for the care of the aged, without the necessity that such patients satisfy the requirements of having mental illness. This was obviously impractical.

Measures to require the appointment of a director of volunteer activities at the community level in each institution; to provide for state aid to local hospitals maintaining psychiatric facilities; to permit the admission of nonresidents to state hospitals; and to require publication of information on mental hygiene were also introduced, but failed of passage.

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EDITORIAL COMMENT

POST MOLESTAM SENECTUTEM . . .

Work brings its own relief;
He who most idle is
Has most of grief.
—*Eugene Fitch Ware.*

This QUARTERLY has no information as to whether the well-known work of the League of New Hampshire Arts and Crafts has ever been employed for purposes of mental hygiene. If it has not been, we think the possibilities should be investigated by somebody.

The League of New Hampshire Arts and Crafts was founded for economic reasons during the depression, and it continues for economic purposes; but we think both its achievement and its possibilities might well be measured by mental hygiene standards. We have in mind the emotional and financial satisfactions the league brings to all its members, and most particularly the security which the league has assured to many of its older members.

The QUARTERLY editors happen to remember the beginnings of the league a little more than twenty years ago, when the governor of New Hampshire appointed a commission to inquire into a small-town home industries group founded by some energetic women who had been stimulated by the unexpected success of a hooked rug sale. It seemed like a harmless if unprofitable occupation for depression times when classes in handicrafts were set up in small towns throughout the state, and professional and volunteer workers went from farm to farm to teach individuals how to hook rugs, piece old-fashioned quilts or do modern decorative metal work. Farmers with woodworking skills traveled miles on wintry nights to teach others or to improve their own proficiencies. Farm wives taught needle work. The hand loom and the quilting frame reappeared in the farmhouse. Today the league has 3,600 members distributed throughout the state and engaged in crafts ranging from pottery to exceedingly life-like reproductions of New England wild birds.

As we said, what the mental hygiene results of this program may be, we do not know; that is, we have no information suitable for statistical analysis. But we have the opinion, well-founded on

the experience of many years with occupational therapy, that scores of the league's members have been benefited as much emotionally and mentally by its program as they have been financially. For this discussion, we should like to focus on these benefits as brought to the league's older members.

We hardly need to be reminded that with the increase in general life expectancy, and with increasing control over diseases which used to take a fearful toll in middle age, geriatrics has become a growing medical specialty. Almost within our lifetimes, we have seen childhood medicine developed to a specialized status; scientific attention is now being focused on the closing years of life much as it recently was on the years of life's beginning.

Institutional psychiatrists hardly need to be reminded that the proportion of aged to the patient population has so increased that institutional operation as a whole, from the training of residents to the design and construction of new buildings, has been affected. For some years now, our statisticians have been as much concerned with the age make-ups of expected hospital populations as in predicting future totals. And our medical staffs have been devoting increasing attention to treating the physical maladies of the aged and ameliorating symptoms in disorders of aging which range from disturbances with arteriosclerosis to the senile psychoses.

There are more reasons than the increasing life span for the increasing number of aged in our hospitals. Psychiatrists are not in agreement as to what all of them are; and statisticians are not in agreement as to their relative effects; there are too many uncertain factors, and the establishment of controls is too difficult to make reliable statistical analyses. But it seems reasonably clear that America's shift from a predominantly rural to a predominantly urban society, coupled with what might be called urbanization of farm life itself, has something to do with it.

On the farm of a century ago, grandpa could be seclusive or paranoid, and grandma could be hypochondriacal, depressed, or full of fanatical over-religiosity without annoying the family beyond endurance. Nobody would notice anyway if grandpa were just a little queer, but he could be very queer indeed and still occupy himself to some personal satisfaction and considerable social usefulness by such odd jobs as swilling the pigs, scything the farmhouse lawn, sharpening the tools and repairing the family bric-a-

brac. And grandma had such personal jobs as mixing the shortcake dough, baking the county's best pies and putting away the dishes; or, she could retire to some corner and still do the family mending, while enjoying her hypochondriasis, indulging her depression, or reflecting on the extreme wickedness of this world and the rewards to be found by the sufferer in heaven.

There are no lawns to scythe and few tools to sharpen in city apartments; making pies for today's city families is no steady occupation; and grandma has no quiet corner to which to retire with her mending—in the unlikely event that her modern grandchildren wear enough mended clothes to occupy her in the first place. Even on the farm, occupational and social conditions have changed vastly. Machinery has eliminated many of grandpa's chores; with smaller families, grandma's services are in lesser demand in the kitchen, where the bakery truck probably calls anyway; and peculiarities of conduct which could be passed off with a shrug on an isolated farm are socially unacceptable in an age of automobile-visiting.

Grandma's symptoms, and her wailing and gnashing of teeth, are unwelcome accompaniments of radio and television; and grandpa will evoke more than a tolerant chuckle if he wanders around with pants unbuttoned or uses four-letter, barnyard words in front of the company Sandra has brought home for the evening from high school. On the modern farm, as in the modern city home, the old folks have less and less to do, and less and less privacy to do it in.

We are not so simple as our own grandparents were, and we have long since abandoned such simple explanations for mental derangement as bereavement or disappointment in love—even though our official statistics, through sheer love of conservatism, sometimes continue to show them. But we do know—though basic cause it surely is not—that bereavement or disappointment in love can precipitate a psychosis in a person predisposed to one by life experience or constitution.

We know that among precipitating causes of mental disorders of later life, mild or severe, are such things as retirement from activity to sudden idleness, the development of a physical disability, the realization of dependency, the loss of familial affection, and many other common incidents of the process of growing older, including the greatly-maligned menopause. We also know, or think we know, that environmental stress can exacerbate, if not

precipitate, attacks of late middle life arteriosclerosis or other organic psychoses. At any rate, the evidence is convincing that severe emotional stress is something it is just as well to avoid from middle life on; and we have long known that it makes just as good psychiatric sense as it does good common sense for people of middle life and old age to have hobbies.

The League of New Hampshire Arts and Crafts was founded for economic reasons, and it is largely in terms of economics that its present degree of success is measured.* We have no quarrel with this. New Hampshire's just pride is in its scenery, which is not edible. Over many square miles of the state, there is less grass than granite; and if Connecticut farmers ever actually sharpened their animals' noses so they could graze between the stones, they learned the trick from New Hampshire. The New Hampshire farmer of 1800 spent his summer farming land which in many instances was more fertile than it is now, and devoted spare time in the winter, after wood-cutting and ice-harvesting, to such things as the making of furniture, tools and wagons, while his wife spun, wove and made the clothes. His descendants of 1900 bought their furniture from Grand Rapids, and got their tools and wheeled transport ready made, while general store and mail order house provided the family's clothes. But farmer and family might devote spare time and acquire cash income by work in the lumber, cloth and lace mills which dotted the banks of the state's many streams. When the depression of the 1930's destroyed this cash income, it is reasonable to see, in the revival of home handicrafts, chiefly the economic aspect.

What we should like to have now is a look at this great craft program from the emotional health and human happiness viewpoint. We suspect there is something in it which might be applied elsewhere to present-day problems which are only in part economic. We should like to know how the young fellow feels who gave up city life, failed to make a living at farming, and now supports his family by constructing models and toys in his home workshop. We should like to have a few interviews by trained people with older women who have been making more quilts and weaving more scarves as their housework lessened. We should like to know how satisfying life is to the fellow who whittles models

*They Give Craftsmen a Break. By Robert Scharff. American Legion Magazine, May 1952.

of wild birds from soft wood, and whether the retired business man who now makes silver hollow ware and jewelry regrets that he retired. And what of the basket maker, the potter and the wood turner? We wonder if we could not acquire, from some or all of these, some points applicable in the psychiatry and mental hygiene of our older people.

We are not suggesting that we, or any other state, copy New Hampshire; we do not see, for instance, how an organization adapted for farm and small-town craftsmanship could function efficiently in our great cities—or how many of the activities employed could even be carried on in a city. Neither are we suggesting that anything attempted be organized by the state—ours or any other. We should want more assurance first that a worthwhile program could be developed, and second, that such a thing was necessarily a governmental function.

What we do suggest is that it would be a very worthwhile project for private philanthropic endeavor to investigate the mental hygiene aspects of New Hampshire's 20-year program, and, then, if they were found valuable, to institute a test project devoted to mental hygiene ends in some district where both urban and rural problems might be studied. What we have in mind might involve in part the encouragement of hobbies from chess to stamp collecting and in part the conduct of what we might call extra-curricular occupational therapy in the encouragement of home handicrafts, with sale of the work made possible. We see no reason why the teaching of handicrafts, the jury system of maintaining high standards and the provision of suitable sales outlets could not be managed as well by a private organization as by one that was state-sponsored. There would have to be safeguards, of course, against commercializing the idea for sweat-shop purposes, and safeguards against producing and selling home craft work calculated in type and prices to hurt small business or full-time workers. And there might also have to be ways and means worked out to see that this sort of mental hygiene effort did not conflict with old-age assistance allowances and could be carried on—with appropriate financial arrangements—by persons drawing public or private disability incomes.

Psychological research has pretty well exploded the ancient superstition that old dogs can't be taught new tricks. With the lengthening life span comes the necessity of teaching some old dogs

new ones. Adult education is nothing new; but adult education for senescence would be. We think it is time we did some thinking about it and time we did some active encouragement of it. What we propose here is not so much new in itself but is new in its purpose and application. The New Hampshire home craft industry exists; shops where convalescent patients may learn trades and work under carefully-supervised conditions exist. Adult education classes are conducted in most cities. What we propose is to combine features of these activities and see if we cannot set up something of use in the way of preventive psychiatry, or if one prefers, mental hygiene with a specific application. It seems reasonable to suppose that if the futility of loss of occupation or loss of interests, or complete loss of earning capacity, can precipitate a mental breakdown, appropriate preventive measures might forestall one. We suggest that the occupational possibilities of the home handicrafts—or, in the cities, of the neighborhood workshop—be investigated as one such preventive measure.

The idea may be impractical. But we can't tell that without trying it. And it may work. If it does, it should save much in human happiness. It might, in fact, save more. If it works, it might even save tax funds and private expenditures for medical specialists and hospitalization—in other words, save money.

BOOK REVIEWS

Are Your Troubles Psychosomatic? By J. A. WINTER, M. D. 218 pages. Cloth. Julian Messner. New York. 1952. Price $3.50.

These days the public hears so much about "psychosomatics" that there has been a need for a book which contains elemental reasoning so that the lay person can understand what psychosomatic medicine means and get away from the notion that a person who has a psychosomatic illness is "insane." *Are Your Troubles Psychosomatic?* is the first such book which your reviewer has seen. It contains information which any person can understand. It is a good book for public libraries and doctors' offices. Also, it contains valuable ideas and explanations which the average doctor could use in his practice. The author addresses his book to the lay person and, in his preface, states, "In the first place this book will not be a substitute for the attentions of your family physician. On the contrary, many of the concepts and techniques which will be discussed can be used only by one who has had considerable training in the healing arts. Yet we feel that you will be better able to work with your doctor when or if the necessity should arise."

The author first defines "psychosomatic" in very simple language. He then tells the reader of circumstances where a person might psychologically profit by being ill, of guilt feelings, of the building up of anxiety and of the conversion of these reactions into physical symptomatology. Through very brief case records, he demonstrates to the reader sexual abnormalities, allergies, ulcers and glandular defects caused by psychological conflicts. He explains the "language" which emotions use.

Finally, Dr. Winter describes methods for gaining self-understanding and writes, "Every moment in life has an intensity all its own. We can feel it and make it ours forever—or we can blind ourselves, deafen ourselves, deaden all our senses until our living becomes a dull gray mockery of life. We can choose to learn to be more alive, knowing that it's not an easy process, but recognizing that the rewards will more than repay the effort expended. There are experiences which, if we permit, can warp us into a practice for dying—but this doesn't have to happen. We can take the energies of these experiences and re-direct them into the path of living. Living can be joyful and good. We hope that you can find it so."

You're as Young as You Act. By MARGERY WILSON. 288 pages. Cloth. Lippincott. Philadelphia and New York. 1951. Price $3.95.

The promise inherent in the title of this volume is undoubtedly inspiring. But the inference and implication of its author is that youth can be

achieved by concocting certain preferred ingredients, much like a recipe for salad dressing.

The familiar tocsin of the hucksters, "do this" and "do that" to be beautiful . . . to be irresistible . . . to be happy, is rung insistently with frequent capitalized comments that only serve to accentuate a shallow and egotistical literary style.

Some of the author's material has a certain practical value—so much so that a certain type of reader might be forgiven for believing that such methodology works for everybody. However, if the choice of reading it and remaining young or discarding it and growing old exists, this reviewer believes that he would vote in favor of the latter.

Projective Test Productions I. Projective Drawings. By CLAIRE MEYERS VERNIER. 168 pages. Paper. Grune & Stratton. New York. 1952. Price $6.00.

The need for standard references for figure drawings has grown with the current upsurge of their use as a projective technique in the assessment of personality. This volume represents a step in that direction, although it is intended primarily as an instruction aid in the classroom.

Despite the fact that each drawing is accompanied by a diagnostic label, the author laudably notes that her aim is to provide the opportunity for students to study psychodynamics, as they are reflected in the various syndromes, through the medium of projective drawings. She cautions that her work is not to be used as a cook-book method for interpreting drawings blindly, but is rather intended to aid in the novice's understanding of the technique.

The productions are from cases culled from a basic collection—because of their clear-cut clinical features—cases of the so-called "text-book" variety. Included are drawings by psychotics, neurotics, organics (with and without psychosis) and mental defectives. In each case, the photographed copy of the drawing is given, 60 in all, accompanied by the age and sex of the subject, diagnostic category, salient clinical notes and interpretations from the drawings reflecting the clinical features.

Noteworthy is the author's inclusion of some "normal" drawings and the admonition interjected to the overzealous who are prone to making flash interpretations.

A comprehensive bibliography is provided.

The People's Psychology. By F. M. GREGG, Ph.D. 466 pages. Cloth. Vintage Press. New York. 1951. Price $5.00.

The author of this book is apparently well-trained in the field of psychology. He has attempted to present the concepts of psychology at a level calculated to be readable by the general lay public. The style is interesting and the explanations simple, still the nomenclature of the field is

introduced. The physiology of the nervous system as well as such psychological phenomena as thinking; knowledge; personality, both normal and abnormal; and theories of mind are discussed. The author's approach, however, is rather dogmatic and would appear to depart from opinions generally prevalent in the field.

Throughout the text, he makes statements such as the following in reference to gambling: "Any proclivity so completely universal must have a deep-seated hereditary root. That root is certainly the inborn urge for collecting and is one of the very strong supporting arguments for a dual brain. . . ." He continues, "In order to put zest in a social game of cards, prizes are offered to the winner even though both womanhood and manhood thus stand debauched." The former statement would most certainly arouse argument among his colleagues, and the latter statement seems psychological gaucherie. The author succeeds, nevertheless, in simply and interestingly imparting a great deal of knowledge, although the rationalistic air which permeates his writing robs the book of much value; and the rather unusual and naïve viewpoint makes the book too bigoted in this reviewer's opinion, to be recommended as a contribution to the cause of popular understanding of psychology.

Sex After Forty. By S. A. Lewin, M. D., and John Gilmore, Ph.D. 200 pages including index. Cloth. Grosset & Dunlap. New York. 1952. Price $3.50.

This is a friendly and informative book, intended for general readers who want or need information about what the dust jacket calls "the turbulent years." The language is simple, plain and understandable; the purpose is plainly reassurance and encouragement. The greater part of this volume, however, might have been written before dynamic psychiatry was ever heard of. If there is no prudery in treatment—and there is not—there seems to have been some in selection. The subjects of impotence and frigidity are missing from the index and there is no mention of the paraphilias. The authors do, however, report on a patient who had "difficulty in achieving erection" and who was relieved by "psychotherapy for a short period" and his wife's "warm devotion." They report, without adequate explanation, on another man who was found to be "considerably improved" after nearly a year of psychoanalysis in respect to premature ejaculation. Another patient with this symptom was treated with local anesthesia on the head of the glans penis, plus a condom.

This book should be of some value to the theoretically normal person who has no real problems of middle age except ignorance. It is, however, worse than inadequate, either as information or guide, for anybody of either sex who is approaching the climacteric with ordinary neurotic reactions. The psychiatrist certainly would hesitate to recommend it.

Medical Ethics and Their Effect Upon the Public. By LOUIS GUENZEL. 79 pages. Cloth. Vantage Press. New York. 1951. Price $2.00.

By means of this book, the author, a Chicago architect, heaps criticism upon the medical profession. He reports several cases where secret medical formulas or types of advertising by doctors, or clinics controlled by one doctor, or so-called "institutes," have failed to receive recognition by the medical profession. The author believes that such failure leads to denying the poor man proper medical care, leads to an autocratic medicine and eventually, to socialized medicine.

The author fails to realize that the medical profession truly has ethics which are near to sacred. He fails to realize that doctors share knowledge with one another and that "trade" secrets are not condoned. It is true that medical care comes high, but one doubts that the author has found a solution.

Introduction to Murder. By WENZELL BROWN. 232 pages. Cloth. Greenberg. New York. 1952. Price $2.75.

Wenzell Brown gives here an excellent journalistic account of the notorious case of the "lonely hearts" killers, Raymond Fernandez and Martha Beck, who died in New York State's electric chair. It is, however, even in the discussion of the difficulties of the psychiatric witness and of the medico-legal aspects of the trial, strictly journalistic. Most of it is the sort of reading which the interested person could find for himself, including the discussion of the psychiatry involved, in the files of the New York papers, reporting the murder and its outcome. It is not in any sense a study, and the psychopathology of Fernandez and Mrs. Beck can only be inferred. There is a chapter devoted to the general aspects of the lonely hearts club racket. This would be a useful warning to the naïve, were any of the naïve to read it.

Every Crazy Wind. By JOHN WALLACE PRITCHARD. 242 pages. Cloth. Dodd, Mead. New York. 1952. Price $3.00.

Here is one of those confused books which force upon the reader a quick decision: whether to put it aside, or to assume that the author had, after all, a satire on psychiatry in mind. Having tentatively decided for the latter, the mood of the reader changes: Great expectations are evoked. Many objections have been leveled against members of our profession—lack of sense of humor is not among them. But the satire is disappointing: The inane story of a patient fooling psychiatrists, the not less inane female psychologist who falls in love with the patient (she attaches herself to him at the psychiatrist's order to establish "transference"); all this is stale and boring. The book proves how difficult it is to write a good satire on psychiatry.

Psychology. By Ross Stagner and T. F. Karwoski. 546 pages. Cloth. McGraw-Hill. New York. 1952. Price $5.00.

Your reviewer would judge that this volume is a particularly good textbook for the student who is taking his first year in the study of psychology. It is a well-planned book; the type is good; and each page has two narrow columns of print for easier reading. The price, too, is very reasonable for the student.

The opening chapter, "Orientation," defines the study of psychology and describes briefly the many schools and trends of the discipline. The book is then divided into three parts: "Dynamics," "Cognition" and "Personality." Just what these contain is best described by the author:

"Our first steps toward insight into psychology are in the field of dynamics. We must look for an answer to the question, why? What desires, fears, ambitions and aspirations motivate man's behavior? This is an area about which there is a good deal of misconception in popular thinking about psychology; scientific analysis leads to rejection of many of these common beliefs.

"In the second portion of this book we shall deal with material which is less disturbing. The question asked is: how does man go about satisfying his desires? The answers delve into the field of sensory psychology (how we get information about the world), learning to respond appropriately to this information, remembering, thinking, and intelligence. This area corresponds to the 'rational psychology' of the Ancient Greeks.

"The concluding series of chapters again may get into some emotionally toned topics. There we shall deal with personality formation, how the individual learns to handle conflicts of motives, how psychologists study, describe, and measure personality. Since personality depends upon all psychological processes—motivation, perceiving, learning, thinking—these chapters will try to unify all the facts and theories presented in the earlier sections."

Following each chapter, the author lists references, and at the end of the book there is a large bibliography as well as a name index and a general index.

The Vintage. By Anthony West. 310 pages. Cloth. Houghton-Mifflin. Boston. 1950. Price $3.00.

This reviewer is always amused when he discovers that a severe literary critic simply cannot write. West's book is a case in point; it is boring, confused, inconsequential. At the same time, West is a young critic who throws his weight around, condemning, criticizing *ex cathedra*. As a creative writer himself, he falls short to an amazing degree. His book purports to be a discussion of man's conscience; it is adolescent cynicism min-

gled with adolescent whining. The theme is ludicrous: A British lawyer, serving on the War Crimes Commission, prepares the case against a German general, who is condemned to be hanged. Afterward, the accuser commits suicide, and is chained in "eternity" to the general. There is an unsuccessful attempt at political satire: Eternity is conducted along the lines of an authoritarian concentration camp. But not even the satirical line is worked out; one thinks in contrast of the brilliant futuristic books of Huxley and Orwell.

The author's inability to formulate the problem of conscience is astonishing: "The moralist is merely purging himself of the guilt slapped on him when an aunt boxed his ears for watching two coupling dogs—our lives are shaped by accidents which scar and wound our unconscious mind [p. 66]."

The ABC's of the genesis and working of the inner conscience are unknown to the author.

The Last Years of Nijinsky. By ROMOLA NIJINSKY. 260 pages including index. Cloth. Simon and Schuster. New York. 1952. Price $3.50.

Romola Nijinsky records here the story of the heartbreaking 27 years which followed the outbreak in 1919 of the psychosis of her great dancer-husband, Vaslav Nijinsky. Romola Nijinsky accompanied her husband on his weary pilgrimage from treatment to treatment, saved his life from the Nazi threat and the threat of invasion during the second World War, and nursed him through his last days in England. Her tale shows all the tolerance and sympathy of a devoted, almost worshipful, woman; but she is astonishingly frank within the limitations of her adoration—even as to her husband's homosexuality—and the course of his illness and treatment are easy enough for the informed to follow.

This account of the tragedy of a great artist can be recommended unreservedly for reading by all who have psychological understanding.

The Best of Modern Humor. Selected by P. Wodehouse and Scott Meredith. 263 pages. Cloth. Metcalf Associates. New York. 1952. Price $2.75.

This is a well-selected collection of modern humor, ranging from Stephen Leacock to the *New Yorker*. The tall story which denies human impotence, the broad satire on manners, the immigrant finding humor in his own provincialism and twisted English, are present and well accounted for. Wodehouse himself represents the English. Of considerable psychological interest is Earl Wilson's selection on "silver-tongued orators." It is an all-too-brief compilation of slips of the tongue, and more.

Rorschach's Test. Vol. III, Advances in Interpretation. By SAMUEL J. BECK. 301 pages. Cloth. Grune & Stratton. New York. 1952. Price $5.50.

This book is the long-awaited Volume III by Dr. Beck on the Rorschach Test. Volumes I and II were published in 1944-45 with a second edition of Volume I, on scoring, published in 1949 and revised in 1950. Volume II, on interpretation, dates back to 1945. Because of the considerable research done on the Rorschach in recent years, the present volume has been eagerly awaited by clinical psychologists. The plan of the present book is in some ways similar to, and in some ways different from, Volume II. As in the previous volumes, Dr. Beck begins with a theoretical chapter on the personality; Chapter II is an important chapter, "Advances in Interpretation." The rest—and this is the main body of the book—is devoted to discussions of four cases, including Rorschach results, and discussion of therapy including notes of the therapeutic sessions. Thus Volume III presents fewer cases but more detailed discussions of them than were given in Volume II. A final chapter, Synopsis and Comment, Critical and Speculative, completes the book.

The Weakling and the Enemy. By FRANCOIS MAURIAC. 219 pages. Cloth. Pellegrini & Cudahy. New York. 1952. Price $3.00.

Two short stories—excursions into hate and love, respectively—show Mauriac as a skillful descriptive writer—no more. His reputation as one of France's greatest contemporary writers could hardly be deduced from this book. He depicts battles of conscience, simplifies, however, both conflicts and protagonists. He is better in describing hate. ("We speak of 'making love': we should be able, too, to speak of 'making hate.' To make hate is comforting. . . .") It is strange also that his "bad" women (Paula and Fanny) are more alive in these narratives than their religious adversaries with whom the author's sympathies lie.

Six Angels at My Back. By JOHN BELL CLAYTON. 200 pages. Paper. Macmillan. New York. 1952. Price $1.50.

Clayton's novel has been widely advertised as a departure in publishing. It is a first-rate piece of literature, printed on good paper and issued in paper covers. Apparently this is in hopes of reaching a market in America comparable to that of continental Europe, where the reader may buy books cheaply—and bind at his own expense only those he judges worth preservation.

Six Angels at My Back is a tale of Florida, of the southern people one sometimes hears called "crackers." It has been described justly as tightly and vividly written. Its motivations are psychological and economic; this reviewer thinks the psychology is sound; and the book can be recommended as good adult reading for the psychologically informed.

More Power to Your Mind. By G. Milton Smith. 167 pages. Cloth. Harper. New York. 1952. Price $2.50.

This is a naïve self-help book for borderline cases between healthy emotional state and neurosis. In the author's words, "It offers some organized common sense on mental health and power which can act as a guide to more effective living." "Organized common sense" seems in need of some reinforcement, hence a psychiatric authority is called in—the columnist, John Chamberlain, who writes in the preface:

"For some twenty-five years, in one capacity or another, I have seen books on popular psychology come over my desk for review. Most of them I have ducked for the simple reason that they were offensive to common sense. . . . G. Milton Smith's *More Power to Your Mind* is the work of a 'sane man's psychologist.' . . . I trust that I will not seem too bewildering if I say that *More Power to Your Mind* is the best work on popular psychology since James Thurber came up with the immortal idea expressed in the title, *Let Your Mind Alone.*"

This journalistic "psychology" covers adequately the "merits" of the book. The only question which remains to be answered is: Why does a reputable publisher give his imprint to so much trash?

Christmas Without Johnny. By Gladys Hasty Carroll. 230 pages. Cloth. Macmillan. New York. 1950. Price $2.50.

What happens to a child's world when adult pressures impinge on it and family, teacher and church, who control that world, all forget how vital to it are affection and security? Johnny's story might be the story of any nine-year-old who yearns for understanding and, lacking it, tries to cope with problems which a small measure of parental insight could eliminate.

It is a sad truth that adulthood which should bring wisdom brings oftener a dulling of those perceptions that could bridge the gulf between us and our children. The author manages to show both child and adult points of view in this story while still visualizing effectively the penalties that ignorance always exacts.

Johnny is alive and charming. If his parents and teachers develop too sudden a change of heart in time of crisis to be completely convincing, the book's theme of a child's need for intelligent guidance is still largely unimpaired.

The Square Peg. By George Malcolm-Smith. Pictures by Carl Rose. 246 pages. Cloth. Doubleday. New York. 1952. Price $2.75.

Malcolm-Smith, with the able assistance of Carl Rose, presents an elaborate spoof of psychology. It is strictly good, clean horseplay; and once one has accepted the fact that Harvey B. Hines was such a psychologist as never was or will be, one can relax and enjoy the pie-throwing.

The Art of Group Discipline. A Mental Hygiene Approach to Leadership. By RUDOLPH M. WITTENBERG. ix and 124 pages. Cloth. Association Press. New York. 1951. Price $3.00.

The author of *So You Want to Help People* has written another rather popular and intelligent book entitled *The Art of Group Discipline*. In this mental hygiene approach to leadership, Rudolph M. Wittenberg writes a treatise on discipline and its problems that is useful for parents, teachers, leaders, and ministers. The book abounds in good examples of group discipline in a democracy. The author rightly feels that discipline starts early in life and is a dominant factor in living. In fact, the book is dynamic enough so that its thesis is that discipline is a process, not an emergency measure.

Freedom and discipline are related, according to Mr. Wittenberg. Discipline is a process of change in the individual, in the group, and in society. The book's viewpoint is buttressed by brief condensations of scientific studies and authoritative opinions in the field. The author deals fundamentally, with group discipline and matters of leadership, and then devotes individual chapters to the individual, the community, the leader, and the group, with their relationships. He views discipline as the slow process of growth toward inner control. Throughout this little volume, Mr. Wittenberg emphasizes the understanding, the tact, and the firmness with insight, required to promote, not too much and not too little, inner control. The learning of group discipline, finally, is seen as an essential of democratic society.

The Psychology of Thinking. By W. EDGAR VINOCKE. 392 pages. Cloth. McGraw-Hill. New York. 1952. Price $5.50.

This book is a systematic, up-to-date survey of the "variety of human thought processes, together with what the psychologist has found out about them." The author, who is associate professor of psychology at the University of Hawaii, gives a thorough discussion stressing, *human, normal* thinking with emphasis on experimental findings in these fields. Beginning with a definition of thinking and its historical background, the author devotes chapters to: Consciousness and the Field of Attention, and Ideas, Imagery and Imageless Thought. There is an analysis of the Mechanism of Thinking and chapters on Logic, Concept Formation, Problem-Solving, Imagination, Autistic Thinking, Creative Thinking, and The Internalization of Experience. Some of the social aspects of thinking, such as attitudes, stereotypes and rumor are discussed.

The book is well written and includes the classical as well as the most recent experimental studies, with critical evaluations of them. It is recommended as a comprehensive study and up-to-date survey of research in the psychology of thinking.

Spinoza Dictionary. By DAGOBERT D. RUNES. xiv and 309 pages. Cloth. Philosophical Library. New York. 1951. Price $5.00.

With a foreword by Albert Einstein, *Spinoza Dictionary* is edited by Dagobert D. Runes, who has attempted to sift through the massive, rigid structure of Spinoza's writings and clarify the thought of the great philosopher. In Spinoza's work, are many new concepts and metaphysical views, written by an outwardly cold and collected person, but a man in whose heart and mind burned the ravages of love, devotion and pride. Spinoza was a man troubled by great desires and deep emotions. Plagued, during his brief lifetime, by the devils of mistrust and misunderstanding, Spinoza yet found the path that only angels truly tread. In this short book, Dr. Runes has had to consolidate, and also omit, much of the intricate weavings of Spinoza's thoughts. Notwithstanding, the book is interestingly sound, varied, and a treasury of the highlights of the philosopher's wisdom.

Spinoza Dictionary is a reliable guide, especially as it concerns itself with the philosopher's *Ethics*. It is beyond equivocation by now that Baruch Spinoza was one of the cardinal thinkers of all times; and, in this book, the author has done a fine job of editing into succinct form the eternal questions of man and his passions, God and nature as Spinoza himself viewed them.

The Tall Headlines. By AUDREY ERSKINE LINDOP. 326 pages. Cloth. Macmillan. New York. 1950. Price $3.00.

Here is a naïve attempt to dabble with a psychological problem, with the saving grace of a relatively interesting plot. A young man kills his sweetheart with a stone; after his execution, the younger brother starts to identify with the murderer. A series of situations is constructed by the author to that purpose, till at the end, the external similarity is reproduced. But the murderer-to-be does not kill at all. All this is described without the slightest insight; not even reasonable rationalizations are provided. It all goes to show that plot and execution are not identical in a novel, especially, when the author has the pronounced reverse of a flair for psychological interconnections.

Children Who Never Had a Chance. By LUCY FREEMAN. 24 pages. Paper. Public Affairs Pamphlets. 22 East 38th Street, New York. 1952. Price 25 cents.

This short pamphlet is a dicusssion by a well-known writer on psychiatric and sociological subjects for the layman. It is chiefly an explanation of the progress of Federal Aid to Dependent Children and is a spirited defense of it. It is a document which is well worth the attention of all psychiatric and other scientific workers in contact with the problems of underprivileged children—and this regardless of whatever personal opinion one may have concerning the theories of federal aid and its application.

CONTRIBUTORS TO THIS ISSUE

RALPH W. COLTHARP, M. D. Dr. Ralph W. Coltharp was steadily gaining prominence among the younger workers in child guidance and juvenile delinquency when he died on May 24, 1952. After some years of service as director of clinical services at the Kansas Boys Industrial School, Topeka, he had become director of Dallas Child Guidance on October 1, 1951. A graduate in medicine of the University of Texas in 1942, he had been in medical practice for only 10 years at the time of his death. Dr. Coltharp's psychiatric training was at St. Elizabeths Hospital, the U. S. P. H. S. Hospital, Ft. Worth, Texas, and the Menninger School of Psychiatry; and he served as a naval psychiatrist during World War II. While serving at the Kansas Boys Industrial School, he worked with Mr. Weber, coauthor of his present contribution, on the establishment of a dynamic approach to treating delinquents in Kansas; and a previous paper by them on this subject was published in Part 2 of THE PSYCHIATRIC QUARTERLY SUPPLEMENT for 1950. Dr. Coltharp was a diplomate of the American Board of Psychiatry and Neurology.

GEORGE H. WEBER, M. A. Mr. Weber is a clinical psychologist who has served at the Kansas Boys Industrial School for the past five years. Born in South Dakota in 1921, Mr. Weber holds bachelors' degrees from the University of South Dakota and Northern State Teachers College (South Dakota). His M. A. in psychology is from the University of Kansas. Mr. Weber received his clinical training in the Menninger Foundation clinical training program. During World War II, he was a personnel officer with the marine corps.

MARY ALICE WHITE, Ph.D. Dr. White is head of the psychology department at New York Hospital—Westchester Division, White Plains, N. Y., and is a consulting psychologist in White Plains. Born in Washington, D. C., she is a graduate of Vassar and holds a Ph.D. from Columbia. She was formerly resident psychologist, then assistant psychologist at the New York Hospital—Westchester Division. She is a member of the American Psychological Association.

HANNA SCHREIBER, M. A. Miss Schreiber is at present in psychological practice in New York City. Born in Austria, she is a graduate of Hunter College and of Columbia. Her training was at New York Hospital—Westchester Division, where she was formerly assistant psychologist.

EDMUND BERGLER, M. D. Edmund Bergler is a psychoanalyst in private practice in New York City and is widely known as a writer on psychoanalytic subjects for both general and professional reading. He is a graduate of the medical school of the University of Vienna, was formerly assistant director of the psychoanalytic clinic in Vienna, and was widely known in European scientific circles before coming to this country. His published books and articles number well over 100, in both this country and Europe; and he has been a frequent contributor to THE PSYCHIATRIC QUARTERLY.

PAUL WENGER, M. D. Dr. Wenger was graduated from the University of Vienna in 1921. He received his psychiatric training at the University Hospital in Vienna, where he practised psychiatry for 10 years, affiliated with the analytical schools of Freud and Adler. He was a psychiatric consultant with the Austrian Federal Health Insurance Fund for Employees of Industry and Trade and a lecturer in mental hygiene at one of the Vienna city colleges. In 1942 he was licensed to practice in New York. He then was a senior psychiatrist with the New York State Department of Correction and the New York State Department of Mental Hygiene. From 1942 to 1945, he also was a consultant at the Rochester Guidance Center. Since 1946, he has been with the Veterans Administration. A fellow of the American Psychiatric Association, he has published numerous scientific papers dealing with psychotherapy, child guidance work, alcoholism, penal psychiatry, and preventive psychiatry.

A. A. KURLAND, M. D. Dr. Kurland was born in 1914 and obtained his medical degree from the University of Maryland in 1940. His internship was served at the Sinai Hospital in Baltimore, from 1940 to 1941. From 1941 to 1945, he was on active military service and was awarded the Legion of Merit. For the past several years, he has been on the staff of the Spring Grove State Hospital, Catonsville, Md. He is a diplomate of the American Board of Psychiatry and Neurology and has published several scientific papers. At the present time he is also a psychiatric consultant at the Aberdeen Proving Grounds.

MILTON V. KLINE, Ph.D. Dr. Kline is a member of the department of psychology of Long Island University, and is psychologist of the division of mental hygiene, Westchester County (N. Y.) Department of Health. He is consultant in clinical psychology at the Westchester Psychological Service Center, and is editor of *The Bulletin* of the Society for Clinical and Experimental Hypnosis.

WILLIAM T. LHAMON, M. D. Dr. Lhamon is associate professor of psychiatry at the School of Medicine of the University of Pennsylvania. Born in Washington, D. C., in 1915, he is a graduate of Stanford University and of Stanford University Medical School, from which he received his medical degree in 1940. He interned at San Francisco City and County Hospital in 1939 and 1940 and held an assistant residency in neuropsychiatry at the Stanford University Hospital in San Francisco in 1940 and 1941. Dr. Lhamon trained in psychiatry at the Payne Whitney Clinic, New York Hospital, and Cornell Medical School in 1941 and 1942 and from 1946 to 1948.

MARIANNE WALLENBERG-CHERMAK, M. D. Dr. Wallenberg-Chermak is clinical director of Manteno (Ill.) State Hospital. She is a graduate in medicine of Heidelberg University in 1930. She was with the Neurological University Clinic and the Medical University Clinic in Heidelberg, then with the Psychiatric-Neurological University Clinic in Vienna until 1934. She was trained in psychoanalysis in Vienna. After further hospital service in Vienna and in Switzerland, she came to the United States where she joined the staff of Peoria (Ill.) State Hospital in 1939. She has been clinical director at Manteno since 1940. She is staff psychiatrist at the Peoria Mental Hygiene Clinic and is a diplomate in both psychiatry and neurology of the American Board of Psychiatry and Neurology. Dr. Wallenberg-Chermak is the author of a number of scientific articles published both in Europe and this country, chiefly on neurological and psychiatric subjects and including a previous contribution to THE PSYCHIATRIC QUARTERLY.

ZYGMUNT A. PIOTROWSKI, Ph.D. Dr. Piotrowski is principal research scientist (psychology) of the New York State Department of Mental Hygiene for the research project in sex delinquency from which the article by him and Dr. David Abrahamsen in this issue of THE PSYCHIATRIC QUARTERLY SUPPLEMENT originated. He is an associate editor of this QUARTERLY, is chief clinical psychologist at the New York State Psychiatric Institute, is associate in psychiatry at the College of Physicians and Surgeons, Columbia University, and is adjunct associate professor of psychology in the Graduate School of Arts and Sciences, New York University. He is chairman of the section of psychology of the New York Academy of Sciences and a member of the council of that academy. He is past president of the Rorschach Institute.

Dr. Piotrowski was born in Poznam, Poland in 1904. He received his Ph.D. from the University of Poznam and did further graduate study at the University of Paris, Columbia and Bellevue Hospital, specializing in

psychology. Dr. Piotrowski is the author of numerous publications on various psychological and psychiatric subjects, including "A Rorschach Compendium," which now forms the greater part of the textbook, *A Rorschach Training Manual,* sponsored by THE PSYCHIATRIC QUARTERLY and published by The State Hospitals Press.

DAVID ABRAHAMSEN, M. D. Dr. Abrahamsen, widely known as an authority on criminal psychopathology, was director of New York State's research project in sex delinquency when the paper was written on which he and Dr. Zygmunt A. Piotrowski collaborated—and which appears in this issue of THE PSYCHIATRIC QUARTERLY SUPPLEMENT—a position he resigned last spring.

Now in private practice in New York City, Dr. Abrahamsen is a native of Norway and a graduate in medicine at Oslo in 1929. He was psychiatrist at the department of justice in Oslo before the Nazi invasion of Norway and continued specializing in psychiatric criminology when he came to this country. He was appointed psychiatrist to the Illinois State Penitentiary in 1941 and has served as psychiatrist at Bellevue Hospital and at the psychiatric clinic of the Court of General Sessions, New York City. He has conducted postgraduate courses at Columbia and at the Psychiatric Institute. Dr. Abrahamsen's extensive published writings include discussion of crime on the international scale, *Men, Mind and Power,* as well as texts on general criminology, *Crime and the Human Mind.* He considered the German leaders to be incurable common criminals, not criminals in any such special sense as "war criminals," but criminals like common murderers, rapists, thieves and arsonists. He organized and headed a Norwegian field hospital at the time of the Nazi invasion and before his escape to America, and so came in personal contact with Nazi ruthlessness and with the treason and collaboration which abetted it. A work on still another aspect of criminology, *Who Are the Guilty?* a study of education and crime, was published this year.

HIRSCH LAZAAR SILVERMAN, Ph.D. Dr. Silverman is a clinical psychologist now doing private counseling in Newark, N. J. He is a teacher of philosophy and psychology and has published monographs and articles, both for professional groups and the general public, on both subjects. He is assistant professor of psychology at Newark College of Arts and Sciences, Rutgers University. Born in New York City in 1915, he is a graduate of the College of the City of New York and holds masters' degrees from that college and from New York University; he received his Ph.D. from Yeshiva University in 1951. During military service in World War II, in which he was, first, military psychologist and personnel consultant, and

later intelligence officer in the Pacific area and Japan, he also studied at Yale and at the University of Virginia. Besides college and university teaching, Dr. Silverman has taught in the public elementary and high schools and has been a psychiatric social worker. Before going to Rutgers, he had served from 1946 to 1948 as resident head and assistant professor of philosophy at Mohawk College, Utica, N. Y.

Dr. Silverman is a member of the American Philosophical Association, the American Psychological Association, and other professional groups. He lives in Newark, N. J., is married and has three children.

MARSH W. BRESLIN, LL.B. Mr. Breslin is senior attorney of the legal bureau of the New York State Department of Mental Hygiene. Born in Waterford, N. Y., in 1904, he is a graduate of Harvard College in 1926 and of Albany Law School in 1930. He was in private law practice until 1932 when he became affiliated with the Albany County Welfare Department. He left that department to join the Department of Mental Hygiene in 1942.

CHARLES BUCKMAN, M. D.

Dr. Charles Buckman, assistant commissioner of the New York State Department of Mental Hygiene, was named senior director of Kings Park State Hospital by Commissioner of Mental Hygiene Newton Bigelow, M. D., on June 1, 1952. He fills the vacancy left by the retirement of Dr. Arthur E. Soper as Kings Park director.

Dr. Buckman had been in charge of the department's New York City office for almost two years before his transfer to Kings Park. He was promoted from director of Gowanda State Homeopathic Hospital and assigned, as assistant commissioner, to New York City, on October 15, 1950. He had been director at Gowanda since May 1949.

Born in 1899, Dr. Buckman was educated in Quebec, receiving his medical degree from McGill in 1922. With the exception of some special work at Montefiore Hospital, New York City, in 1925 and 1926, and army service in World War II from 1943 to 1946, he has been with the New York State hospital system since 1923, when he joined the staff of Brooklyn State Hospital. He became assistant director of Creedmoor in 1941 and had returned to Creedmoor from military service when he was appointed to head Gowanda.

Dr. Buckman is a diplomate in psychiatry of the American Board of Psychiatry and Neurology and is a member of the American Psychiatric Association and other professional societies. His wife, the former Bertha Dee, is a native of Minnesota.

CHARLES BUCKMAN, M. D.

HENRY BRILL, M. D.

HENRY BRILL, M. D.

Henry Brill, M. D., director of Craig Colony, Sonyea, N. Y., was appointed assistant commissioner of the New York State Department of Mental Hygiene, on July 1, 1952, by Commissioner of Mental Hygiene Newton Bigelow, M. D. Dr. Brill had been director of Craig Colony for two years, having been appointed from the position of acting associate director of Pilgrim State Hospital on June 1, 1950. He has been with the New York State service for 30 years, ever since his graduation from Yale Medical School in 1932.

Dr. Brill was born in Bridgeport, Conn., in 1906 and attended the public schools of that city before entering Yale College, where he was graduated in 1928. He held several scholarships and is a member of Phi Beta Kappa. Dr. Brill is a diplomate of the American Board of Psychiatry and Neurology in both psychiatry and neurology. He is a member of the American Psychiatric Association and other professional societies and is past president of the Long Island Psychiatric Society.

The new assistant commissioner is author or co-author of a number of scientific papers on various forms of shock therapy and on prefrontal lobotomy. As assistant commissioner, he is assigned to the departmental administrative offices at Albany.

Dr. Brill is married to the former Wenonah Beale. There are two children, Helen Elizabeth and Michael Henry. His hobbies are sketching, reading and bicycling.

ROBERT C. HUNT, M. D.

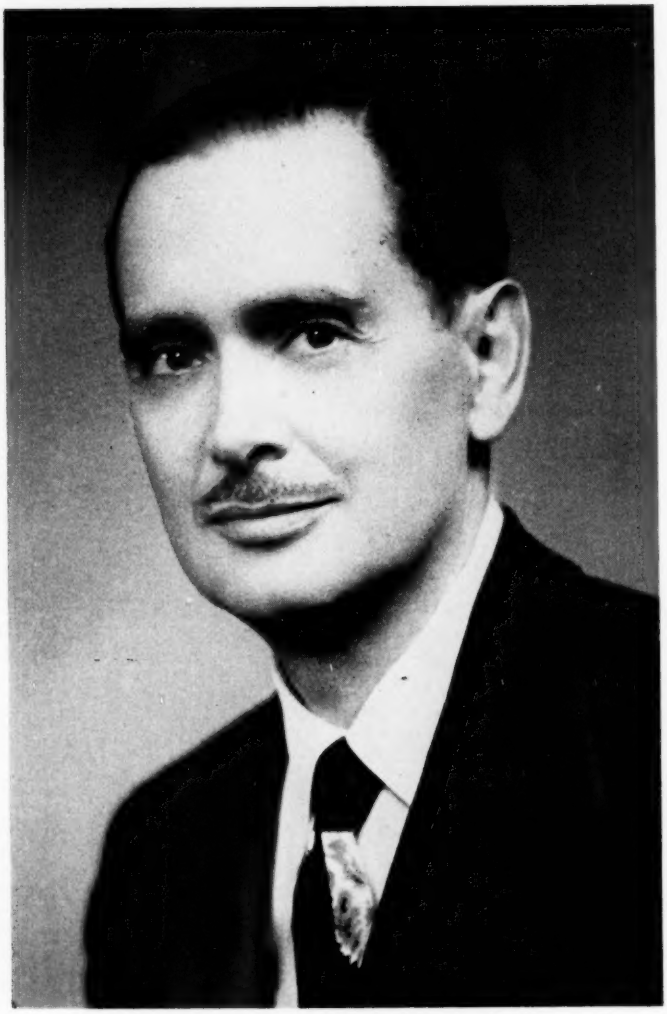
Robert C. Hunt, M. D., was appointed assistant commissioner of the New York State Department of Mental Hygiene on July 1, 1952 by Commissioner Newton Bigelow, M. D., and assigned to the Albany office. He had been director of St. Lawrence State Hospital since March 1, 1950.

Robert Hunt was born in Egypt in 1905, a son of the Rev. James G. Hunt, a missionary and theological seminary professor. His early education was in Cairo, then at Cambridge, N. Y., after coming to this country at the age of 12. He attended high school at Cambridge and at Ben Avon, Pa., where he was graduated in 1921. He attended Westminster College, New Wilmington, Pa., and following his graduation from that school in 1925, taught biology, algebra and French, and was an athletic coach in Pennsylvania high schools before entering the University of Pennsylvania School of Medicine, from which he was graduated in 1931.

Dr. Hunt interned at Bryn Mawr (Pa.) Hospital and served a residency in psychiatry at Strong Memorial Hospital, Rochester, N. Y., before joining the New York State hospital service as an intern at Binghamton in 1933. In 1933 and 1934, he was a fellow in psychiatry at the Institute of the Pennsylvania Hospital; and in 1935, he joined the Rochester State Hospital staff. He was assistant director at Rochester when he was appointed director at St. Lawrence.

Dr. Hunt served with the army from 1942 to 1946 and received the army commendation ribbon for the organization and operation of a mental hygiene consultation service in the Infantry Replacement Training Camp at Camp Wolters, Texas. He is a lieutenant-colonel in the medical corps reserve. At Rochester, Dr. Hunt was on the staff of the University of Rochester School of Medicine and Dentistry and was assistant psychiatrist at Strong Memorial Hospital. He is past president of the Monroe County Mental Hygiene Society. Dr. Hunt is a fellow of the American Medical Association and of the American Psychiatric Association and a member of other professional organizations. He is author or co-author of a number of scientific publications, including several in THE PSYCHIATRIC QUARTERLY. Dr. Hunt is a yachtsman, a member of the Rochester Yacht Club and the Rochester Power Squadron. He was married to Dolly Cassidy of Burgettstown, Pa., in 1929, and they have two children.

ROBERT C. HUNT, M. D.



JAMES A. BRUSSEL, M. D.

JAMES A. BRUSSEL, M. D.

Dr. James A. Brussel, assistant director of Willard State Hospital, was named assistant commissioner of the New York State Department of Mental Hygiene by Commissioner Newton Bigelow, M. D., on June 1, 1952. He succeeds Dr. Charles Buckman, transferred to the senior directorship of Kings Park State Hospital, in charge of the department's New York City office.

Dr. Brussel is widely known as a writer on scientific subjects, has contributed many articles to THE PSYCHIATRIC QUARTERLY and THE PSYCHIATRIC QUARTERLY SUPPLEMENT, and is co-author with Kenneth S. Hitch of a paper dealing with military and civilian uses of the Rorschach examination which is now a part of *A Rorschach Training Manual,* published by the State Hospitals Press. Dr. Brussel was a pioneer in introducing the use of the Rorschach in the armed forces.

Born in New York City in 1905, Dr. Brussel is a graduate of both the college and the medical school of the University of Pennsylvania. He had a two-year internship at Beth Israel Hospital, New York City, where he ended his service as house surgeon. During his state service, he has done postgraduate work at Columbia University and the New York State Psychiatric Institute in psychiatric and neurologic subjects including electric shock therapy and electro-encephalography.

Dr. Brussel was on leave from Willard for army service from July 1, 1951 until May 15 of the present year, serving as lieutenant-colonel at William Beaumont Army Hospital, Fort Bliss, Texas. He had been recalled to active duty after having served during World War II from 1940 to 1946 as chief of various army neuropsychiatric services, including hospital ship duty. The army Certificate of Merit was awarded to him at Fort Dix in 1945.

Dr. Brussel holds certificates in both neurology and psychiatry from the American Board of Psychiatry and Neurology. He is a fellow of the American Medical Association and the New York Academy of Medicine, is a fellow (asso.) of the American College of Physicians, and is a member of the American Psychiatric Association and other professional organizations.

Besides his scientific writing, Dr. Brussel is a writer of popular humorous and serious prose (including fiction) and poetry. He is a constructor of crossword and other puzzles and is a cartoonist. Aside from scientific and other journals addressed to the medical profession, his work has appeared in *Judge,* the *New Yorker,* the *New York Herald-Tribune* and other general publications. Dr. Brussel gives his hobby as music. He is an enthusiastic musician, and plays the organ, the piano, the saxophone and the tympani; he was formerly tympanist with the New York Doctor's Orchestral Society.

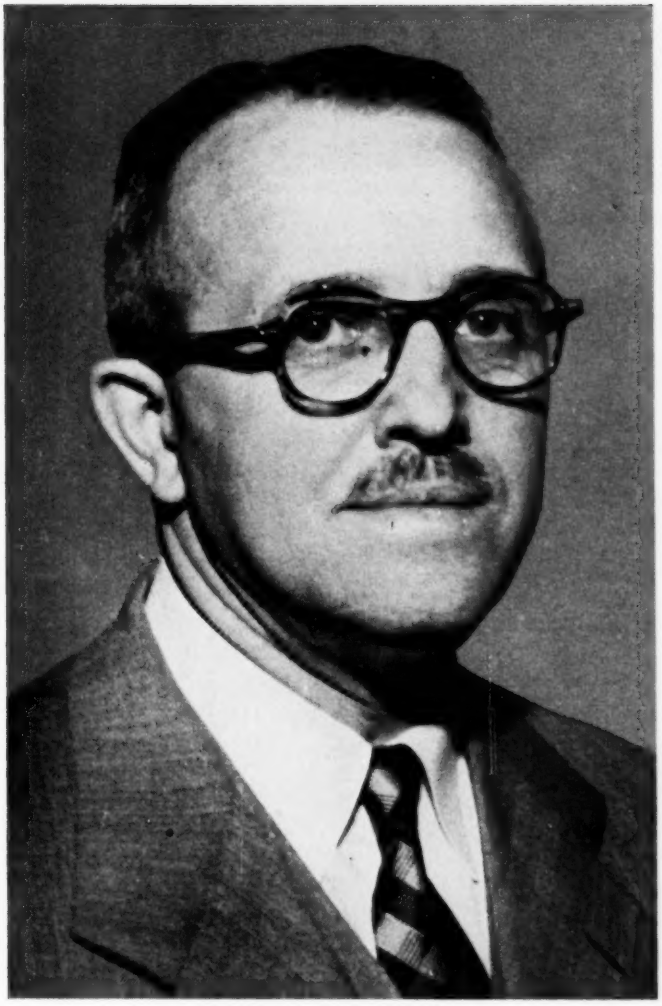
GEORGE F. ETLING, M. D.

George F. Etling, M. D., assistant director of Rome State School, was appointed director of St. Lawrence State Hospital on July 1, 1952, by Commissioner Newton Bigelow, M. D., of the New York State Department of Mental Hygiene. Dr. Etling had been assistant director at Rome since 1944. He succeeds Dr. Robert C. Hunt, named assistant commissioner.

Born in Buffalo in 1903, George F. Etling was graduated from the University of Buffalo College of Medicine in 1928. He has been in the New York State hospital service since 1929, when he joined the Buffalo State Hospital staff, except for service as lieutenant-commander in the medical corps, U. S. naval reserve, during World War II.

Dr. Etling transferred from Buffalo to Rockland in 1931 and remained there, in successive grades, until his appointment at Rome. He did graduate study in neurology and psychiatry at the New York State Psychiatric Institute, and study in general, surgical and neurological pathology at the New York Postgraduate Hospital, while he was assigned to Rockland.

Dr. Etling is a fellow of the American Association on Mental Deficiency, and his other memberships include the American Medical Association, the Oneida County Medical Society, and the Mohawk Valley Neuropsychiatric Society.



GEORGE F. ETLING, M. D.

DUNCAN WHITEHEAD, M. D.

DUNCAN WHITEHEAD, M. D.

Dr. Duncan Whitehead, assistant director of Brooklyn State Hospital and acting editor of THE PSYCHIATRIC QUARTERLY and this SUPPLEMENT, was appointed director of Buffalo State Hospital by Commissioner Newton Bigelow, M. D., of the New York State Department of Mental Hygiene on July 1, 1952. Dr. Whitehead fills the vacancy left by the retirement of Dr. Christopher Fletcher as Buffalo director.

Dr. Whitehead had been assistant director at Brooklyn since 1946. The senior associate editor of the QUARTERLY, he has been acting editor since Dr. Bigelow, shortly thereafter appointed commissioner, gave up the active editorship to become acting commissioner of the Department of Mental Hygiene in April 1950. He has been a member of the QUARTERLY editorial board since 1940.

Born in Lynn, Mass., in 1905, Dr. Whitehead attended the public schools of Lynn and Fitchburg before going to Cornell University where he received his bachelor's degree in 1926. During the next two years he was assistant, then instructor, in anatomy, receiving his master's degree in 1928. He received his M. D. from Cornell University Medical School in 1931, served for a short time at Utica (N. Y.) State Hospital, then served an internship at Bellevue, where he remained for two years. He entered state hospital service permanently in 1934 and, except for military service in World War II, has remained with the New York State hospital system ever since.

He served in the army from 1941 to 1946, both in this country, chiefly at Lowell General Hospital, Fort Devens, Mass., and overseas, for most of the period with the rank of lieutenant-colonel. He was discharged as a colonel.

Dr. Whitehead had served in the various grades at Utica and held the post of assistant director (clinical) there when he transferred to the same position at Brooklyn in 1946. He is the author of a number of papers on mental hygiene and psychiatric subjects, and, while at Brooklyn, served as assistant professor of clinical psychiatry at the College of Medicine of the State University Medical Center at New York (formerly the Long Island College of Medicine). He is a diplomate of the American Board of Psychiatry and Neurology, a fellow of the American Psychiatric Association and the American College of Physicians, a member of the American Medical Association and other professional societies. Dr. Whitehead is married and has one son.

CHARLES GREENBERG, M. D.

Dr. Charles Greenberg, assistant director at Harlem Valley State Hospital, Wingdale, N. Y., was appointed director of Craig Colony, Sonyea, N. Y., on July 1, 1952, by Commissioner of Mental Hygiene Newton Bigelow, M. D. He succeeds Dr. Henry Brill, appointed assistant commissioner.

Dr. Greenberg was born in New York City in 1906. He attended Fordham University for two years, then New York University, from which he received his B. S. degree in 1927. After two years at Dartmouth, he entered Rush Medical College of the University of Chicago, where he was graduated with his M. D. degree in 1931.

After two years internship, including a residency in neurology at City Hospital, Welfare Island, N. Y., and a residency in psychiatry at Syracuse Psychopathic Hospital, he entered the New York State hospital service at Harlem Valley State Hospital in 1935. He progressed through the grades there to the post of assistant director.

Dr. Greenberg served as lieutenant-commander in the navy during World War II and is now in the reserves. He is a member of the American Psychiatric Association, the American Medical Association and other professional societies.

He was married to Ruth Ostroff in 1940, and they have two children, Ellen Ann and Nina Jean. He lists his "principal" hobbies as gardening, cooking and bowling.

CHARLES GREENBERG, M. D.

NEWS AND COMMENT

CLARENCE H. BELLINGER, M. D., BROOKLYN DIRECTOR DIES AT 65

Clarence H. Bellinger, M. D., head of Brooklyn State Hospital since July 1, 1935, died unexpectedly of a heart attack at that institution on August 12, 1952. He had been in the New York State service for 42 years and had been the only head of Brooklyn—first with the title of superintendent, later as senior director—since the two former divisions of Brooklyn were made separate institutions as Brooklyn and Creedmoor State Hospitals. He was 65 years old.

Brooklyn State Hospital, under Dr. Bellinger's leadership, was a pioneer institution in the development of insulin, metrazol and electric shock therapies; and its patient capacity was greatly increased. As a program in which he took great personal interest, the ties of the hospital with the community it served were greatly strengthened by a variety of mental hygiene endeavors. With his support the work of the Gray Ladies of the Red Cross became an important feature of the hospital program. Another notable example was his encouragement of the Brooklyn State Hospital Forum, formed by officers and employees to sponsor public lectures by outstanding authorities on psychiatry. Commenting on this phase of Dr. Bellinger's career, Dr. Newton Bigelow, commissioner of mental hygiene, said that his program had served "as an inspiration for hospital-community co-operation throughout the state."

Clarence H. Bellinger was born in Lebanon, Madison County, N. Y., on February 22, 1887; he attended the public schools and Smyrna High School and, in 1910, was graduated with his M. D. degree from the Syracuse College of Medicine. He entered the New York State service in August of that year as an intern at St. Lawrence State Hospital, transferring the following year to Binghamton. He was promoted to senior assistant physician and transferred to Utica State Hospital in 1910; he became clinical director at Utica in 1926 and first assistant physician there shortly afterward. He had been acting assistant medical inspector for something more than a year when he was appointed superintendent at Brooklyn by Commissioner Frederick W. Parsons.

Dr. Bellinger was active in promotion of Brooklyn's mental hygiene and child guidance clinic programs, work in which he had had previous extensive experience. He had been in charge of the mental hygiene clinic at Binghamton for several years; and, for five years, had conducted the mental hygiene clinic at the Syracuse Free Dispensary in conjunction with the College of Medicine of Syracuse University. At Brooklyn, he was di-

rector of the Brooklyn Neuropsychiatric Clinic, a privately-supported medical service which he helped to organize a decade ago. He was author or co-author of numerous scientific papers and reports and was a lecturer on psychiatric and mental hygiene subjects. He was professor of psychiatry at the Long Island College of Medicine, now the College of Medicine of the State University Medical Center at New York.

Dr. Bellinger was a diplomate in both neurology and psychiatry of the American Board of Psychiatry and Neurology. He was a fellow of the American Psychiatric Association and the American Medical Association and a member of various other professional societies.

After opportunity had been given at Brooklyn for friends and associates to pay tribute to Dr. Bellinger, his body was taken to Sherburne, N. Y. There was a brief service and burial there at West Hills Cemetery.

GROUP PSYCHOTHERAPISTS TO MEET IN JANUARY

The Tenth Annual Conference of the American Group Psychotherapy Association has been announced for January 9 and 10, 1953 at the Henry Hudson Hotel, New York City. Six panel meetings will be features of the gathering. Lewis H. Loeser, M. D., is president of the association.

NEW BUFFALO BUILDING RECEIVES FIRST PATIENTS

Buffalo State Hospital's new 617-bed medical and surgical building, on which construction was started in 1949, is being formally dedicated on October 14, 1952. The new building, costing $4,747,000, is part of the state's $178,000,000, 14,000-bed construction program, which will benefit 17 institutions. It is the second of several medical-surgical buildings to be completed—the first was dedicated at Hudson River State Hospital last June. The first 200 patients to occupy the new building were moved in late in August.

NEW PSYCHICAL RESEARCH PUBLICATION ISSUED

Tomorrow, a new digest described as the world's first in the fields of psychical research and occult studies, is being issued by Garrett Publications, with Eileen J. Garrett editor and publisher. Vol. 1, No. 1, is the issue of "Autumn 1952," and the publication is to be a quarterly. The first issue contains, among other articles: "Old Black Magic Reborn" by Albert Schweitzer; "The Ghost of Ash Manor," a report from Eileen Garrett's files; "Diagnosis Miracle," an article on medical studies of the phenomena at Lourdes; and "The Tormented Soul of Paracelsus," by Jack O'Brien.

RECREATIONAL THERAPY ORGANIZATION IS ANNOUNCED

Formation of a Recreational Therapy Section has been announced by the American Association for Health, Physical Education, and Recreation. Action was taken at the 1952 convention of the association in Los Angeles in April to make a separate section for the recreational therapists, heretofore included in the association's division of institutional and industrial recreation. B. J. Rudquist of the Veterans Administration Hospital, Palo Alto, Calif., head of the old division, continues as chairman of the new one.

THE PSYCHIATRIC QUARTERLY SUPPLEMENT

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